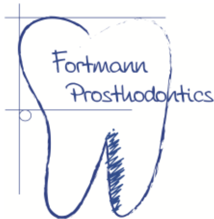


Christine A. Fortmann, DDS, Inc.
32281 Camino Capistrano, Suite C-102, San Juan Capistrano, CA 92675
Phone: (949) 429-8833 Fax: (949) 493-0114 FortmannDDS@gmail.com

PATIENT INFORMATION

Today's Date:			
First Name	**Middle**	**Last Name**	**Preferred Name**
DOB:	**Gender:**	**SSN:**	
Address:		**City:**	**Zip:**
Primary Phone: ( )	**Secondary Phone:** ( )		
Email:			
Emergency Contact: Name & Relationship		**Phone Number:**	
What is your preferred contact method?			

DENTAL HEALTH HISTORY

What are your goals in coming to Dr. Fortmann today?

____

What has been your experience with the dentist in the past?

____

Who referred you to Dr. Fortmann?

____

Have you had problems with prior dental treatment?

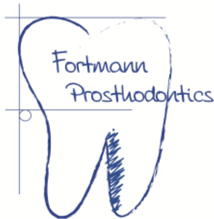
____

Have you ever ben pre-medicated for dental treatment?

____

What concerns do you currently have with your oral health or smile? (check all that apply)

- ☐ Jaw joint pain
- ☐ Clenching or grinding of teeth
- ☐ Discolored teeth
- ☐ Crowding/Crooked teeth
- ☐ Missing teeth
- ☐ Spaces in between teeth
- ☐ Loose tooth/teeth
- ☐ Tooth shape or size
- ☐ Unhappy with appearance of teeth
- ☐ Overbite
- ☐ Underbite
- ☐ Uncomfortable bite
- ☐ Old fillings
- ☐ Old crowns
- ☐ Speech problems
- ☐ Too much gum tissue when I smile
- ☐ Tooth sensitivity
- ☐ Food gets caught in between teeth
- ☐ Difficulty chewing
- ☐ Bad breath
- ☐ Other ________________________



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MEDICAL HISTORY

Please list all physicians currently treating you:

____

Please list all allergies (including allergies to medication, latex, food or metal):

____

Are you or could you be pregnant?

____

Have you experienced any of the following? (Please circle Yes or No for each)

Yes / No	Chest pain (angina)	Yes / No	Ringing in ears	Yes / No	Joint pain or stiffness
Yes / No	Blood in stools	Yes / No	Persistent cough	Yes / No	Bleeding problems
Yes / No	Frequent vomiting	Yes / No	Headaches	Yes / No	Blurred vision
Yes / No	Fainting spells	Yes / No	Swollen ankles	Yes / No	Shortness of breath
Yes / No	Dry mouth	Yes / No	Coughing up blood	Yes / No	Bruise easily
Yes / No	Fever	Yes / No	Dizziness	Yes / No	Sinus problems

Have you had or do you have any of the following? (Please circle Yes or No for each)

Yes / No	Heart disease	Yes / No	Hepatitis	Yes / No	Hardening of arteries
Yes / No	AIDS/HIV	Yes / No	Heart defects	Yes / No	Emphysema or lung disease
Yes / No	Surgeries	Yes / No	Tumors or cancer	Yes / No	Liver disease
Yes / No	Psychiatric care	Yes / No	Sexual transmitted disease	Yes / No	High blood pressure
Yes / No	Osteoporosis	Yes / No	Heart murmurs	Yes / No	Kidney or bladder disease
Yes / No	Heart attack	Yes / No	Chemotherapy	Yes / No	Eye disease
Yes / No	Hospitalization	Yes / No	Herpes	Yes / No	Seizures
Yes / No	Thyroid disease	Yes / No	Rheumatic fever	Yes / No	Stroke
Yes / No	Artificial joint	Yes / No	Radiation	Yes / No	Transplants
Yes / No	Diabetes	Yes / No	Canker or cold sores	Yes / No	Cosmetic surgery
Yes / No	Asthma	Yes / No	Skin disease	Yes / No	Eating disorders
Yes / No	Stomach problems or ulcers	Yes / No	Arthritis, rheumatism	Yes / No	Family history of diabetes or heart disease
Yes / No	Tuberculosis	Yes / No	Anemia		

Have you taken or used any of the following in the last 3 months? (Please circle Yes or No for each)

Yes / No	Recreational Drugs	Yes / No	Tobacco or nicotine in any form	Yes / No	Antibiotics
Yes / No	Over-the-counter medicines	Yes / No	Alcohol	Yes / No	Bisphosphonate (like Fosamax)
Yes / No	Weight loss medications	Yes / No	Aspirin		

Do you have or have you had any other diseases or medical problems NOT listed on this form?

____

Is there any issue or condition that you would like to discuss with Dr. Fortmann in private?

____

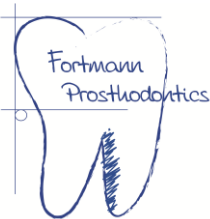
Please list all medications or supplements you are taking and reason: (list on reverse if more space is needed)

____

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically compromised situation, medical consultation may be needed prior to commencement of dental treatment. I authorize the dentist to contact my physician.
I also certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold Dr. Fortmann, or any other member of her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Patient's signature: ______________________ Date: ____________

Patient's name (please print): ______________________



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PATIENT RESPONSIBILITIES

We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with our practice.

Payment: Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. We accept the following forms of payment: Cash, Personal Check, Visa, Mastercard and Discover Card. We do not accept medical or dental insurance as payment.

Scheduling of Appointments: We reserve the doctor's time on the schedule for each patient procedure and are diligent about being on time. Because of this courtesy, when a patient cancels an appointment, it affects the overall quality of service we are able to provide. To maintain the utmost service and care, we do require 48-hour notice to reschedule an appointment. With less than 48-hour notice, a fee or deposit to reserve the appointment time again, may be required. To serve all of our patients in a timely manner, we may need to reschedule an appointment if a patient is 15 minutes late or more arriving to our practice. To reschedule an appointment due to late arrival, a fee or deposit to reserve the appointment time again, may be required.

I have read the above and agree to the financial and scheduling terms.

_______ (initial)

PATIENT COMMUNICATIONS

Messages: I understand messages from the dental practice may be left on my home answering machine or with anyone who answers the telephone at my home unless I have provided the practice with alternate instructions for communication.

_______ (initial)

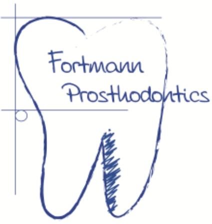
Email: We may use email to electronically communicate with our patients and referring doctors. **Unencrypted email is not a secure form of communication.** There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by unauthorized third parties. However, you may consent to receive unsecured email from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication.

I consent and accept the risk of receiving information via unsecured email. I understand I can withdraw my consent at any time.

_______ (initial)

Cellphone: I consent to the dental practice using my cellphone number to call or text regarding appointments and to call regarding treatment and my account. I understand that I can withdraw my consent at any time.

_______ (initial)



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PATIENT ACKNOWLEDGEMENTS AND AUTHORIZATIONS

I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment.

_______ (initial)

I hereby acknowledge that a copy of this practice's (HIPAA) **Notice of Privacy Practices** has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

_______ (initial)

I hereby acknowledge that a copy of the California Board of Dentistry's **Dental Materials Fact Sheet** has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet.

_______ (initial)

Patient signature: ____ Date: ______________________

Patient name (please print) ______________________________________.