MARK S. DEWAELE, D.M.D.

WILLIAM J. CAPPELLO, D.M.D.

Patient_____

Last First Middle Initial

Address_____Town_____ Zip_____

Sex: M F Birthdate_____ Age_____ Single Married Widowed Divorced

Cell:_____Work:_____Home:_____

Please circle preferred contact: Cell Work Home

Employed by:_____ Occupation:_____
Spouse/Parent Name:_____
Spouse/Parent employed by:_____ Occupation:_____
Who is responsible for payment:_____
Emergency Contact:_____
Referred by:_____
Physician's name:_____Date of last physical:_____

Check if you have ever had:

__Artificial Joints	__Heart Problems	__Circulatory Problems	__Arthritis
__Artificial Heart Valve	__Epilepsy	__Chemical Dependency	__Ulcer
__A-fib	__Stroke	__Low Blood Pressure	__Sinus Issues
__High Blood Pressure	__Cancer	__Swollen Neck Glands	__Headaches
__Kidney Disease	__General Allergies	__Heart Murmur	__Psychiatric care
__Pacemaker	__Respiratory disease	__Hepatitis/Liver Disease	__HIV/AIDS
__Diabetes	__Blood Disease	__Immunosuppressive Disorder	__Hemophilia
__Asthma	__Radiation Treatment	__Chemical Dependency	__Back Problems
__Rheumatic Fever	__Mitral Valve Prolapse	__Nervous Problems	__STD

Do you have any drug allergies or have you ever had an adverse reaction to any medication? Y N

If yes, what medications?_____

Please list medications you are taking:_____

Are you currently under the care of a physician? Y N For what condition?_____
Women: Do you suspect/are you pregnant: Y N Are you nursing? Y N
Are you taking Fosamax? Y N
Is there anything else we should know about your medical/dental history?_____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance claims. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. Signed:_____Date: _____

E-Mail:_____