

Peter Haupers, Jr., D.D.S., M.S.



Russell J. Cecala, D.D.S., M.S.

Periodontics and Dental Implants

Welcome to our office!

Please take a few minutes to give us a brief medical and dental history. The more we know about you, the better we can help you.

Last Name _____ First Name _____
Social Security# _____ Date of Birth _____
Address _____ Home Phone _____
City _____ State _____ Zipcode _____
Cell Phone# _____ Email Address _____
Patient Employer _____ Position _____
Employer Address _____ Work Phone _____
Dental Insurance Co. _____ Grp.# _____
Ins. Co. Address _____

Spouse Name _____ Spouse SS# _____
Spouse Employer _____ Position _____
Employer Address _____ Spouses Birthdate _____
Dental Ins. Co. _____ Grp.# _____
Ins. Co. Address _____

I was referred to the office by _____ My general dentist is _____

Are you being treated by a medical doctor now? Yes _____ No _____

If yes, for what condition? _____

Medical doctor's name and address _____

Doctors phone# _____

Have you ever had a reaction to any medicine? Yes ___ No ___ If yes, what reaction?

Do you take any medicines? Yes ___ No ___ (Include aspirin and vitamins)

Medicine _____ Amount _____ How often _____

Medicine _____ Amount _____ How often _____

Medicine _____ Amount _____ How often _____

Medicine _____ Amount _____ How often _____

Have you ever taken Fen-Phen, Redux or any other appetite suppressant drugs? _____

Have you ever taken Fosamax, Actonel, Boniva, Skelid or Didronel? _____

If so, what year did you begin taking this kind of medication? _____

Were you ever told to pre-medicate before your dental visits? Yes ___ No ___

Did you premedicate with antibiotics for any reason today? _____

Do you smoke? Yes No If you ever smoked when did you quit? _____

If yes, how much per day? Cigarettes _____ Cigars _____ Pipe _____

Please turn the page over and continue

