



Advanced Cosmetic Dentistry

MALEK ESRAWI, D.D.S., D.M.D., P.C.
197 BARNSTABLE ROAD
HYANNIS MA 02601
508-771-4044
WWW.CAPECODSMILES.COM

WELCOME

Patient Information

Date _____ Name _____
Last Name First Name Middle Initial

Soc. Sec. # _____ Home Phone (____) _____ Cell Phone (____) _____

Address _____ E-Mail _____

City _____ State _____ Zip _____

Sex: M F Age _____ Birthday ____/____/____
 Married Widowed
 Divorce Single

I would like to be called _____

Patient Employer or School _____ Occupation _____

Employer or School Address _____ Work Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____) _____

Primary Insurance

Patient Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ Soc.Sec. # _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependants covered under this plan _____

Please Complete Both Sides

Medical History

Please circle "Y" or "N" if you ever had, or been treated for any of the following diseases or medical problems:

- | | | |
|---------------------------------------|-----------------------------|-------------------------|
| Y N Hepatitis/Liver disease/Cirrhosis | Y N Anemia, Type : | Y N Sinus Problems |
| Y N Arthritis, Rheumatism | Y N Cough, Persistent | Y N Diabetes |
| Y N High Blood Pressure | Y N Artificial Heart Valves | Y N Kidney Disease |
| Y N Stroke | Y N Artificial Joints | Y N STD |
| Y N Epilepsy/Siezure | Y N Mitral Valve Prolapse | Y N Fainting spells |
| Y N Swelling of Feet or Ankles | Y N Jaw Pain | Y N Asthma/Hey Fever |
| Y N Bruise easily | Y N Heart Murmur | Y N HIV/AIDS |
| Y N Emotional problems | Y N Heart Problems | Y N Headaches |
| Y N Chemotherapy | Y N Cancer | Y N Abnormal Bleeding |
| Y N Radiation Treatment | Y N Rheumatic Fever | Y N Thyroid Dysfunction |
| Y N Respiratory Disease | Y N Hemophilia | Y N Pacemaker |
| Y N Ulcer | Y N Tuberculosis | Y N Tonsillitis |
| Y N Scarlet Fever | Y N Shortness of Breath | Y N Hives or Skin Rush |

Have you been treated for any of other illnesses not listed above? Yes No, if yes, please explain: _____

Are you pregnant? Yes No, if yes, how many months? _____

Are you nursing? Yes No

Do you smoke or use chewing tobacco? Yes No, if yes, how much per day? _____ How Long? _____

Have you had any serious medical problems within the past 5 years? Yes No, if yes, please explain: _____

Have you been **pre-medicated** with **Antibiotics** before dental treatment? Yes No

Do you have or have you had any of the following illnesses?

- | | |
|--|--|
| <input type="checkbox"/> Systemic Shunts | <input type="checkbox"/> Prosthetic Heart Valves/Damaged heart Valves |
| <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Rheumatic Heart Disease |
| <input type="checkbox"/> Heart Murmur/Functional or Non-Functional | <input type="checkbox"/> Acquired Valvular Dysfunction |
| <input type="checkbox"/> Mitral Valve Prolapse with Regurgitation | <input type="checkbox"/> Artificial Joints, or pins or screws in any bones |
| <input type="checkbox"/> Previous Bacterial Endocarditis | |

Are you allergic or have you reacted adversely to?

- | | | |
|-------------------------------------|--------------------------------|-----------------------|
| Y N Penicillin or other Antibiotics | Y N Erythromycin | Y N Local Anesthetics |
| Y N Aspirin | Y N Codeine or other Narcotics | Y N Sulfa Drugs |

MEDICATIONS

List medications you are currently taking:

Other ALLERGIES

Authorization

I understand that the information is correct to the best of my knowledge. I understand it will beheld in the straightest confidence and only be used to improve communication between the doctor and myself. I consent to the doctor or his staff to use any photographs he may take to be used for lecturing, education purposes and use of our website.

Signature _____ Date _____