



# NESTOR D. KARAS

DDS, MD

A PROFESSIONAL CORPORATION

Oral And Maxillofacial Surgery  
Diplomate, American Board Of Oral And Maxillofacial Surgery

## WELCOME TO OUR PRACTICE

Please print legibly...

Date \_\_\_\_\_

PATIENT \_\_\_\_\_ Sex:  M  F  
(First name) (M.I.) (Last name)

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ I.D./ SS# \_\_\_\_\_ Email \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_ Mobile \_\_\_\_\_

Dentist \_\_\_\_\_ Medical Doctor \_\_\_\_\_ Referred By \_\_\_\_\_

Driver's Lic. # \_\_\_\_\_ Nearest Relative \_\_\_\_\_ Phone \_\_\_\_\_  
(Not living with you)

Have you ever been a patient of our practice?  Yes  No Payment Method:  Cash  Check  Credit Card

### WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT?

(If Self, skip to next section)

Self  Spouse  Father  Mother  
 Other \_\_\_\_\_

Name \_\_\_\_\_ I.D./ SS# \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Phone \_\_\_\_\_

### SPOUSE OR OTHER GUARANTOR INFORMATION

(If different from above)

Name \_\_\_\_\_ I.D./ SS# \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Phone \_\_\_\_\_

## INSURANCE INFORMATION

### PATIENT INFORMATION

Student:  Full Time  Part Time School Name/Address \_\_\_\_\_

Marital Status:  Married  Divorced  Legally Separated  Widow  Single

Employed:  Full Time  Part Time  Retired  Not

Do you belong to a PPO or HMO?  Yes  No

Continued...

**DENTAL INSURANCE****PRIMARY DENTAL INSURANCE COMPANY**

Employer \_\_\_\_\_  
 Bus. Address \_\_\_\_\_  
 Bus. Tel. # \_\_\_\_\_ Plan \_\_\_\_\_  
 Ins. Co. Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Tel. # \_\_\_\_\_  
 Group # \_\_\_\_\_ Group Name \_\_\_\_\_  
 Insured Party \_\_\_\_\_ Relation \_\_\_\_\_  
 Sex:  M  F Date of Birth \_\_\_\_\_  
 Street \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_  
 Tel. # \_\_\_\_\_ S.S. # \_\_\_\_\_  
 I.D. # \_\_\_\_\_

**SECONDARY DENTAL INSURANCE COMPANY**

Ins. Co. Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Tel. # \_\_\_\_\_  
 Group # \_\_\_\_\_ Group Name \_\_\_\_\_  
 Insured Party \_\_\_\_\_ Relation \_\_\_\_\_  
 Sex:  M  F Date of Birth \_\_\_\_\_  
 Street \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_  
 Tel. # \_\_\_\_\_ S.S. # \_\_\_\_\_  
 I.D. # \_\_\_\_\_

**MEDICAL INSURANCE****PRIMARY MEDICAL INSURANCE COMPANY**

Employer \_\_\_\_\_  
 Bus. Address \_\_\_\_\_  
 Bus. Tel. # \_\_\_\_\_ Plan \_\_\_\_\_  
 Ins. Co. Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Tel. # \_\_\_\_\_  
 Group # \_\_\_\_\_ Group Name \_\_\_\_\_  
 Insured Party \_\_\_\_\_ Relation \_\_\_\_\_  
 Sex:  M  F Date of Birth \_\_\_\_\_  
 Street \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_  
 Tel. # \_\_\_\_\_ S.S. # \_\_\_\_\_  
 I.D. # \_\_\_\_\_

**SECONDARY MEDICAL INSURANCE COMPANY**

Ins. Co. Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Tel. # \_\_\_\_\_  
 Group # \_\_\_\_\_ Group Name \_\_\_\_\_  
 Insured Party \_\_\_\_\_ Relation \_\_\_\_\_  
 Sex:  M  F Date of Birth \_\_\_\_\_  
 Street \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_  
 Tel. # \_\_\_\_\_ S.S. # \_\_\_\_\_  
 I.D. # \_\_\_\_\_

**HEALTH HISTORY**

To our patients: Oral surgeons primarily treat the area in and around your face and mouth. These are part of your *entire* body, and health problems that you may have or medication that you may be taking, could have an important interrelationship with the care, that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

**REASON FOR TODAY'S OFFICE VISIT:** \_\_\_\_\_

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 1. Height: _____ Weight: _____ Are you in good health?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have there been any changes in your general health in the past year?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you under the care of a physician? Date of last visit: _____<br>If so, for what are you being treated? _____             | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you had any illness, operation or been hospitalized in the past five years?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth? If so, describe where: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have a prosthetic joint/implant? If so, describe where: _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you had a heart valve replacement or vascular graft?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have a history of TMJ (Jaw Joint) problems?   | <input type="checkbox"/> | <input type="checkbox"/> |

**HAVE YOU HAD OR DO YOU CURRENTLY HAVE...**

	Yes	No		Yes	No
9. Rheumatic fever?	<input type="checkbox"/>	<input type="checkbox"/>	36. Thyroid trouble?	<input type="checkbox"/>	<input type="checkbox"/>
10. Damaged heart valves/ mitral valve prolapse?	<input type="checkbox"/>	<input type="checkbox"/>	37. Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
11. Heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	38. Low blood sugar?	<input type="checkbox"/>	<input type="checkbox"/>
12. High blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	39. Kidney trouble?	<input type="checkbox"/>	<input type="checkbox"/>
13. Low blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	40. Are you on dialysis?	<input type="checkbox"/>	<input type="checkbox"/>
14. Chest pain, angina?	<input type="checkbox"/>	<input type="checkbox"/>	41. Swollen ankles, arthritis or joint disease?	<input type="checkbox"/>	<input type="checkbox"/>
15. Heart attack(s)?	<input type="checkbox"/>	<input type="checkbox"/>	42. Stomach ulcers?	<input type="checkbox"/>	<input type="checkbox"/>
16. Irregular heart beat?	<input type="checkbox"/>	<input type="checkbox"/>	43. Contagious diseases?	<input type="checkbox"/>	<input type="checkbox"/>
17. Cardiac pacemaker?	<input type="checkbox"/>	<input type="checkbox"/>	44. Sexually transmitted diseases?	<input type="checkbox"/>	<input type="checkbox"/>
18. Heart surgery?	<input type="checkbox"/>	<input type="checkbox"/>	45. Problems with the immune system?	<input type="checkbox"/>	<input type="checkbox"/>
19. Bronchitis, chronic cough?	<input type="checkbox"/>	<input type="checkbox"/>	46. Delay in healing?	<input type="checkbox"/>	<input type="checkbox"/>
20. Asthma?	<input type="checkbox"/>	<input type="checkbox"/>	47. A tumor or growth?	<input type="checkbox"/>	<input type="checkbox"/>
21. Hay fever / sinus problems?	<input type="checkbox"/>	<input type="checkbox"/>	48. X-Ray treatment / chemotherapy?	<input type="checkbox"/>	<input type="checkbox"/>
22. Tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>	49. Chronic fatigue / night sweats?	<input type="checkbox"/>	<input type="checkbox"/>
23. Emphysema?	<input type="checkbox"/>	<input type="checkbox"/>	50. Are you on a diet?	<input type="checkbox"/>	<input type="checkbox"/>
24. Difficult breathing/other lung trouble?	<input type="checkbox"/>	<input type="checkbox"/>	51. A history of drug abuse?	<input type="checkbox"/>	<input type="checkbox"/>
25. Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	52. A history of alcohol abuse?	<input type="checkbox"/>	<input type="checkbox"/>
26. Blood transfusion?	<input type="checkbox"/>	<input type="checkbox"/>	53. Contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
27. Blood disorder such as anemia?	<input type="checkbox"/>	<input type="checkbox"/>	54. Eye disease / glaucoma?	<input type="checkbox"/>	<input type="checkbox"/>
28. Bruise easily?	<input type="checkbox"/>	<input type="checkbox"/>	55. Mental health problems?	<input type="checkbox"/>	<input type="checkbox"/>
29. Bleeding tendency (abnormal bleed)?	<input type="checkbox"/>	<input type="checkbox"/>	56. A removable dental appliance?	<input type="checkbox"/>	<input type="checkbox"/>
30. Jaundice, hepatitis or liver disease?	<input type="checkbox"/>	<input type="checkbox"/>	57. Pain & clicking of jaws when eating?	<input type="checkbox"/>	<input type="checkbox"/>
31. Infectious mononucleosis?	<input type="checkbox"/>	<input type="checkbox"/>	58. Malignant hyperthermia?	<input type="checkbox"/>	<input type="checkbox"/>
32. Gallbladder trouble?	<input type="checkbox"/>	<input type="checkbox"/>	59. <b>IF YOU ARE HAVING SURGERY</b> <b>TODAY</b> , have you had anything to eat or drink in the last 6 hours?	<input type="checkbox"/>	<input type="checkbox"/>
33. Fainting spells?	<input type="checkbox"/>	<input type="checkbox"/>	60. Who is driving you home? _____		
34. Convulsions, epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>			
35. Stroke?	<input type="checkbox"/>	<input type="checkbox"/>			

**MEDICATION**

ARE YOU NOW TAKING...	Yes	No	Notes	Yes	No	Notes
61. Any kind of medicine, drugs or pills?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
62. Blood thinners (i.e. Coumadin, Plavix, Aspirin, or Advil)?	<input type="checkbox"/>	<input type="checkbox"/>				
63. Diet Pills? (Now or in the past?)	<input type="checkbox"/>	<input type="checkbox"/>				
64. Tranquilizers?	<input type="checkbox"/>	<input type="checkbox"/>				
65. Bisphosphonate Medications (Now or in the past) (i.e.: Fosamax, Zomeda, Actonel)	<input type="checkbox"/>	<input type="checkbox"/>				
66. Any kind of natural product, herbal supplement, or homeopathic remedy?	<input type="checkbox"/>	<input type="checkbox"/>				
67. Please list any other medications you are taking:						_____
						_____
						_____

**ALLERGIES**

ARE YOU ALLERGIC TO OR HAD A REACTION TO...	Yes	No	Notes	Yes	No	Notes
68. Local anesthetics?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
69. Penicillin?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
70. Other antibiotics?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
71. Sodium Pentothal, Propofol, Valium, or other tranquilizers?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
72. Aspirin / ibuprofen?	<input type="checkbox"/>	<input type="checkbox"/>				
73. Codeine or other narcotics?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
74. Other medications?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
75. Latex?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
76. Sulfites, Soy products, or Eggs?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
77. Please list any allergies other than above:						_____

