Richard W. Kaplan M.D., D.D.S.

Oral and Maxillofacial Surgery Referral Form

Richard W. Kaplan, M.D., D.D.S.
Fax: (561) 420-0151

Date of referral: ______________________
Referred by: ______________________ **Office phone/email/fax:** ______________________
Patient name/parent (for minors): ______________________
Patient phone: ______________ **Patient email:** ______________________
Patient INSURANCE information: ______________________

Dentoalveolar surgery:

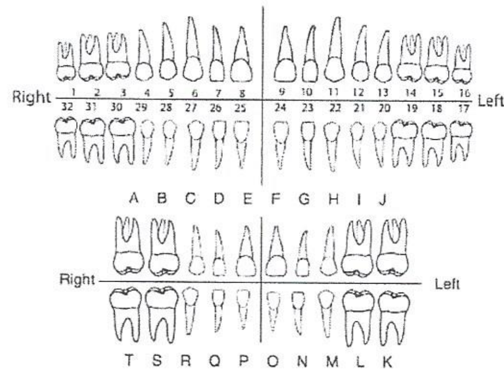
- ❑ Extraction teeth #s: ______________________
- ❑ Alveoplasty: ______________________
- ❑ Incision and drainage: ______________________
- ❑ Biopsy: ______________________
- ❑ Expose and bond: ______________________
- ❑ Frenectomy: ______________________
- ❑ Dentoalveolar trauma: ______________________

- ❑ IV Sedation: ______________________

Dental implants #: ______________________

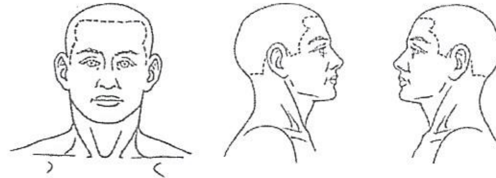
Pathology/Biopsy: ______________________

Please mark teeth to be extracted on diagram



Radiographs:

- ❑ Attached to this referral
- ❑ Will send by email:
- ❑ Will send by US mail
- ❑ None available



Indicate facial injury, swelling or other findings

Medical History:

- ❑ Negative
- ❑ Significant: ______________
- ❑ Special needs: ______________

Palm Beach Gardens Location
1951 Bomar Dr.
Palm Beach Gardens, FL 33408
(561) 848-0553

Wellington Location
1200 Corporate Center Way
Suite 102
Wellington, FL 33414