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

Oral and Maxillofacial Surgery

1951 Bomar Dr. • Palm Beach Gardens, FL 33408 • (561) 848-0553
1300 Corporate Center Way • Suite 102 • Wellington, FL 33414 • (561) 296-0245

Patient First Name: _____M.I.___Last Name: _____
Sex: __Male__Female Date of Birth: _____ Age: ____ SS#: __ __ __-__ __-__ __ __ __
Street: _____City:_____State:___Zip: _____
Home Tel#: ( ) _____ Cell/Work Tel#: ( ) _____ ext _____
Employer: _____ Medical Doctor: _____
Dentist: _____ Have you ever been a patient here? __ Yes __No
Referred By: _____

Who will be responsible for your account: __ Self __Spouse __Father __Mother __Other
First Name: _____ Last Name: _____
Street: _____ City: _____State: ____
Employer: _____Date of Birth: _____ SS# __ __ __ - __ __ - __ __ __ __

HAVE YOU HAD OR DO YOU CURRENTLY HAVE…..

CHECK YES OR NO	Y	N	CHECK YES OR NO	Y	N	CHECK YES OR NO	Y	N
Thyroid trouble			Damaged Heart Valves			Are you nursing		
Diabetes			Heart Murmur			Have you had any food or drink in the last 8 hours		
Low blood sugar			High blood pressure			Do you have someone to drive you home		
Kidney trouble, dialysis			Low blood pressure			Are you on a Diet		
Rheumatic Fever			Chest Pain, Angina					
Arthritis or Joint Disease			Heart Attack			**ARE YOU ALLERGIC TO..**	**Y**	**N**
Stomach Ulcers			Irregular heart beat			Sulfides		
Contagious Diseases			Cardiac Pacemaker			Penicillin		
Sexually transmitted diseases			Heart surgery			Other Antibiotics		
Immune system problems			Bronchitis,Chronic cough			Sodium Pentothal		
HIV			Asthma			Valium or Tranquilizers		
A tumor or growth			Hay fever/sinus problem			Aspirin		
Delay in healing			Infectious Mononucleosis			Codeine or Narcotics		
x-ray/chemotherapy treatment			Tuberculosis			Latex		
Pain and clicking of jaws when eating			Emphysema			Soy		
Mental health problems			Difficulty breathing, other lung trouble			Eggs/ Yolk		
History of drug/alcohol abuse			Malignant hyperthermia			Other _____		
Do you smoke			Blood transfusion			**ARE YOU TAKING…**	**Y**	**N**
Contact lenses			Blood disorder, Anemia			Are you taking Birth Control Pills		
Fainting Spells			Convulsions, epilepsy			Blood Thinners Coumadin,Aspirin,Advil		
Gallbladder Trouble			Bleeding Tendency			Tranquilizers		
Eye disease/glaucoma			Possibility of pregnancy			Ever taken diet pills		
Jaundice, hepatitis, or liver disease			Estimated delivery date ____/_____/_____			Herbal supplements		

- **Please list other medications you are taking** _____
  _____
- Are you in good health? _____ Height_____ Weight_____
- Are you under the care of a physician?_____ Date of last visit:___/___/___
  If so for what are you being treated?_____
- Have you had any illness, operation or been hopitalized in the past five years? _____
- Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth?
  ___ Yes ___ No. If so describe where: _____
- Do you have a prosthetic joint/implant?____If so, describe where:_____
- Have you had a heart valve replacement or vascular graft? _____
- Is there any condition concerning your health the Doctor should be told? ____Yes ____ No
- Is there a family history of ____Diabetes____Cancer____Heart Disease____Anestheic Problems
- **Are you taking any Bisphosphonate drugs or any medications for osteoporosis?** ___Yes ___No

DENTAL INSURANCE INFORMATION

Insured Party_____ Relation_____
Sex: □ Male □ Female Date of Birth: ___/___/___
Street: _____
City, State, Zip_____
Employer: _____ID#:_____
Plan Name: _____
Street: _____
City, State, Zip: _____
Group#:_____ Tel#: _____

MEDICAL INSURANCE INFORMATION

Insured Party_____ Relation_____
Sex: □ Male □ Female Date of Birth: ___/___/___
Street: _____
City, State, Zip_____
Employer: _____ID#:_____
Plan Name: _____
Street: _____
City, State, Zip: _____
Group#:_____ Tel#:_____

OTHER INSURANCE INFORMATION

IS THIS VISIT RELATED TO AN ACCIDENT? ___Yes ___No
□ Auto □ Work related □ Other Date of injury: ___/___/___
Insurance Company Handling Claim: _____
Adjuster: _____ Claim#:_____
Insurance Company Tel. #:_____
Claims mailing address: _____

I certify that I have read and understand the questions above. I have had all my questions if any answered to my satisfaction.

_____ _____

Patient Signature/Guardian **Date**