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
email: info@kaplanoralsurgery.com • **If emergency Please Call:** (561) 848-0553

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

Dentoalveolar surgery:

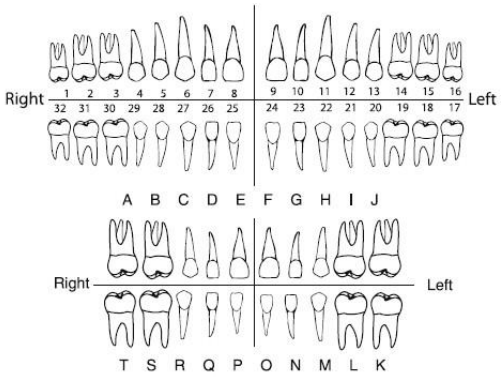
- ❑ Extraction teeth #s:_____
- ❑ Alveoplasty:_____
- ❑ Incision and drainage: _____
- ❑ Biopsy: _____
- ❑ Expose and bond: _____
- ❑ Frenectomy:_____
- ❑ Dentoalveolar trauma: _____

- ❑ IV Sedation:_____

Dental implants #: _____

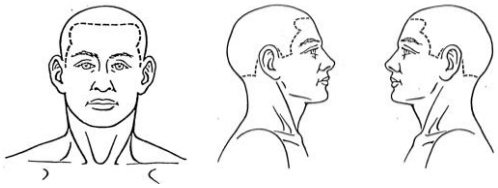
Pathology/Biopsy: _____

Please mark teeth to be extracted on diagram



Radiographs:

- ❑ Attached to this referral
- ❑ Will send by email: (info@kaplanoralsurgery.com)
- ❑ 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
1300 Corporate Center Way
Suite 102
Wellington, FL 33414
(561) 296-0245