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

Oral and Maxillofacial Surgery

1951 Bomar Dr. • Palm Beach Gardens, FL 33408 • (561) 848-0553
1200 Corporate Center Way • Suite 102 • Wellington, FL 33414

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/Sulfa		
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		
Radiation/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**

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OUR FINANCIAL POLICY

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding or our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility. Please read this in its entirety and sign the bottom of this form.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE

MINORS ACCOMPANIED BY AN ADULT: The adult accompanying a minor is responsible for full payment at time of service.

INSURANCE: If you have insurance please notify the office staff prior to your consultation. It is imperative that you present a valid insurance card at the time of your visit. The contract is between you and your insurance company. We are not a party to this contract. We file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual & customary" charges, etc. other than to supply factual information as necessary. **YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT.**

AUTHORIZATION AND ASSIGNMENT: By signing below you authorize the release of any medical, dental or other information necessary to process your claim. You request that payment of authorized Insurance company benefits be made on your behalf to Dr. Kaplan for any services performed by that party who accepts assignment/physician. You understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for your treatment.

MEDICARE/MEDICAID/CHAMPUS/WORKER'S COMPENSATION: If you are covered by any of the above, or any other government sponsored program, please discuss your payment situation with our office staff prior to services being rendered**.**

SHOULD YOU NOT COMPLY WITH THE ABOVE AGREEMENT YOU AGREE TO PAY ALL COLLECTION COSTS AND/OR REASONABLE ATTORNEY'S FEES.

THANK YOU FOR UNDERSTANDING OUR FINANCIAL POLICY. PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS OR CONCERNS.

_____ _____

SIGNATURE DATE

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

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1200 Corporate Center Way, Suite 102 Wellington, FL 33458
(561)848-0553 • Fax (561)420-0151
richard.kaplanmd@gmail.com

CONSENT TO RELEASE PATIENT RECORDS/OTHER INDIVIDUALS AUTHORIZED

I hereby authorize Dr Richard W. Kaplan M.D, D.D.S. to release copies of my medical records to the following individuals, i.e. primary dentist/other physician, family members, friends, etc.

_____

Please print name of individual primary dentist/other physicians.
May we contact the individual? Yes No

_____

Please print name of family member, friend, or other, and their relationship to you, etc. to discuss your care of treatment and/or your billing information.
May we contact the individual? Yes No

I understand that the information in my health record authorized for disclosure may include information relating to sexually transmitted disease (STD), Aid/Arc/ HIV. It may also include information about treatment for alcohol or drug abuse and information about behavior or mental health services (further re-disclosure governed by 42CFR Part2).

I also understand that any topic discussed during my medical treatment was documented, and therefore will be released.

_____ _____

Signature of patient or personal representative Date

_____

Printed name of patient or personal representative and his or her relationship to patient