Brad R. Kaplan, D.M.D., LLC
ORAL, MAXILLOFACIAL, AND IMPLANT SURGICAL CARE

PATIENT INFORMATION

Patient's First Name: _____ Middle Initial: _____ Last Name: _____
Date of Birth: _____ Age: _____ Social Security Number: _____
Street: _____ City: _____ State: _____ Zip: _____
Patient Home Tel: (_____) _____ Bus. Tel: (_____) _____
Primary Physician: _____ Dentist: _____ Referred by: _____
Nearest Relative _____ Tel. # _____ Relation _____
If Full-time College Student, School Name _____ City/State _____

PRIMARY DENTAL INSURANCE

Name of Insurance Co: _____ Policy Holder Name _____
Relationship: ☐ Self ☐ Spouse ☐ Parent Soc. Sec. # : _____
Policy Holder Date of Birth _____ Policy / ID # _____ Group # : _____
Address (if different from above): _____
Employer Name _____ Employer City/State _____

PRIMARY MEDICAL INSURANCE

Name of Insurance Co: _____ Policy Holder Name _____
Relationship: ☐ Self ☐ Spouse ☐ Parent Soc. Sec. # : _____
Policy Holder Date of Birth _____ Policy / ID # _____ Group # : _____
Address (if different from above): _____
Employer Name _____ Employer City/State _____

SECONDARY DENTAL INSURANCE

Name of Insurance Co: _____ Policy Holder Name _____
Relationship: ☐ Self ☐ Spouse ☐ Parent Soc. Sec. # : _____
Policy Holder Date of Birth _____ Policy / ID # _____ Group # : _____
Address (if different from above): _____
Employer Name _____ Employer City/State _____

SECONDARY MEDICAL INSURANCE

Name of Insurance Co: _____ Policy Holder Name _____
Relationship: ☐ Self ☐ Spouse ☐ Parent Soc. Sec. # : _____
Policy Holder Date of Birth _____ Policy / ID # _____ Group # : _____
Address (if different from above): _____
Employer Name _____ Employer City/State _____

OUR FINANCIAL POLICY

One way to keep our fees low is by requesting payment at the time of treatment. We feel that this is fair and prudent, since it eliminates expensive billing costs. Your fee can be paid by cash, check or major credit card. Please remember that insurance is not a substitute for payment. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance company. This office cannot accept responsibility for either the collection of your insurance claim or settlement negotiations on disputed claims.

I will pay for services rendered by: ☐ Cash ☐ Check ☐ MC/Visa/Discover

Signature _____ Date _____