Brad R. Kaplan, D.M.D.
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: ______________________ Subscriber Name: ______________________

Relationship: ☐ Self ☐ Spouse ☐ Parent Soc. Sec. # : ______________________

Date of Birth: ______________ Policy # : ______________ Group # : ______________

Address (if different from above): ____

Employer Name ______________________ Employer City/State ______________________

PRIMARY MEDICAL INSURANCE

Name of Insurance Co: ______________________ Subscriber Name: ______________________

Relationship: ☐ Self ☐ Spouse ☐ Parent Soc. Sec. # : ______________________

Date of Birth: ______________ Policy # : ______________ Group # : ______________

Address (if different from above): ____

Employer Name ______________________ Employer City/State ______________________

SECONDARY DENTAL INSURANCE

Name of Insurance Co: ______________________ Subscriber Name: ______________________

Relationship: ☐ Self ☐ Spouse ☐ Parent Soc. Sec. # : ______________________

Date of Birth: ______________ Policy # : ______________ Group # : ______________

Address (if different from above): ____

Employer Name ______________________ Employer City/State ______________________

SECONDARY MEDICAL INSURANCE

Name of Insurance Co: ______________________ Subscriber Name: ______________________

Relationship: ☐ Self ☐ Spouse ☐ Parent Soc. Sec. # : ______________________

Date of Birth: ______________ Policy # : ______________ 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. We are also pleased to offer Dencharge, an innovative financial plan available immediately for qualified applicants. Our office manager would be happy to discuss this plan with you along with any other questions or concerns you might have. 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 any settlement negotiations on disputed claims.

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

Signature ______________________________________ Date ______________________