ADAMO
DENTAL IMPLANTS & PERIODONTICS

HARKER HEIGHTS **254-680-0223** · WACO **254-754-1456**

Welcome!

We're glad you chose Dr. Adamo for your implant or periodontal needs. In order to make your first visit more efficient, we are providing you with the necessary paperwork to be completed prior to your first appointment.

The following three forms will be either mailed to you, emailed to you, or can be downloaded from our website at **adamodentalimplants.com**.

- ✔ *Patient Registration and Health History*
- ✔ *HIPPA Consent*
- ✔ *Financial Policy*

The forms may be returned by email *(frontdesk@adamodentalimplants.com)* or mail:

**ADAMO DENTAL IMPLANTS & PERIODONTICS**
8418 Old McGregor Rd.
Waco, TX 76712

If you have questions or concerns, we may be reached by phone (254-754-1456 or 877-362-4220) or email *(frontdesk@adamodentalimplants.com)*.

We look forward to meeting you at your first visit!

## INSTRUCTIONS:

Please fill out the form below in Adobe Acrobat and save the file.

Email the completed file to *frontdesk@adamodentalimplants.com*.

You may also print out the completed form and bring it with you on your first visit.

All signatures and dates will be requested on your first visit with us.

# PATIENT REGISTRATION & HEALTH HISTORY

Today's Date: _____

Name: _____ Sex: ❑ Male ❑ Female

*(FULL LEGAL NAME, FIRST THEN LAST NAME)*

Name you preferred to be called? _____ Birth date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

May we email you occasionally with specials and referral program information? ❑ Yes ❑ No

Note, we promise to never SPAM you, and we *never* sell or distribute our patient's information.

Marital Status: ❑ Single ❑ Widow ❑ Married ❑ Divorced Name of Spouse: _____

Person to contact in case of an emergency: _____ Phone: _____

Who referred you to our office? _____

Who is your family/general dentist? _____

## DENTAL INSURANCE

**Primary Insurance Company:** _____ Phone: _____

Claims Address: _____ City: _____ State: _____ Zip: _____

Group Name: _____ Group #: _____

Insured's Name: _____ SSN: _____ Birth date: _____

Insured's Employer: _____ Insured's Relationship to patient: ❑ Spouse ❑ Parent ❑ Child

**Secondary Insurance Company:** _____ Phone: _____

Claims Address: _____ City: _____ State: _____ Zip: _____

Group Name: _____ Group #: _____

Insured's Name: _____ SSN: _____ Birth date: _____

Insured's Employer: _____ Insured's Relationship to patient: ☐ Spouse ☐ Parent ☐ Child

# HEALTH HISTORY

| | | | |
|---|---|---|---|
| Are you under the care of a physician now? | ☐ Yes | ☐ No | ☐ N/A |
| Have you ever been hospitalized or had a major operation? | ☐ Yes | ☐ No | ☐ N/A |
| Have you ever had a serious head or neck injury? | ☐ Yes | ☐ No | ☐ N/A |
| Are you taking any medications, pills or drugs? | ☐ Yes | ☐ No | ☐ N/A |
| Do you take, or have taken, Phen-Fen or Redux? | ☐ Yes | ☐ No | ☐ N/A |
| Are you on a special diet? | ☐ Yes | ☐ No | ☐ N/A |
| Do you use tobacco? | ☐ Yes | ☐ No | ☐ N/A |
| Do you use controlled substances? | ☐ Yes | ☐ No | ☐ N/A |

Women: ☐ Are you pregnant/ trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

If you answered yes to any of the above questions, please explain: _____

**Are you allergic to any of the following?**

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other _____

**Do you have, or have you had any of the following:**

| | | | | |
|---|---|---|---|---|
| ☐ AIDS/HIV Positive | ☐ Chest Pains | ☐ Frequent Headaches | ☐ Irregular Heartbeat | ☐ Scarlet Fever |
| ☐ Alzheimer's | ☐ Cold Sores/Fever Blisters | ☐ Genital Herpes | ☐ Kidney Problems | ☐ Sickle Cell Disease |
| ☐ Anaphylaxis | ☐ Congenital Heart Disorder | ☐ Glaucoma | ☐ Leukemia | ☐ Sinus Trouble |
| ☐ Anemia | ☐ Convulsions | ☐ Hay Fever | ☐ Liver Disease | ☐ Spina Bifida |
| ☐ Angina | ☐ Cortisone Medicine | ☐ Heart Attack/Failure | ☐ Low Blood Pressure | ☐ Stomach/Intestinal Disease |
| ☐ Arthritis/Gout | ☐ Diabetes | ☐ Heart Murmur | ☐ Lung Disease | ☐ Stroke |
| ☐ Artificial Heart Valve | ☐ Drug Addiction | ☐ Heart Pace Maker | ☐ Mitral Valve Prolapse | ☐ Swelling of Limbs |
| ☐ Artificial Joint | ☐ Easily Winded | ☐ Heart Trouble/Disease | ☐ Pain in Jaw Joints | ☐ Thyroid disease |
| ☐ Asthma | ☐ Emphysema | ☐ Hemophilia | ☐ Parathyroid Disease | ☐ Tonsillitis |
| ☐ Blood Disease | ☐ Epilepsy or Seizures | ☐ Hepatitis A | ☐ Psychiatric Care | ☐ Tuberculosis |
| ☐ Blood Transfusion | ☐ Excessive Bleeding | ☐ Hepatitis B or C | ☐ Radiation Treatments | ☐ Tumors or Growths |
| ☐ Breathing Problems | ☐ Excessive Thirst | ☐ Herpes | ☐ Recent Weight Loss | ☐ Ulcers |
| ☐ Bruise Easily | ☐ Fainting Spells/Dizziness | ☐ High Blood Pressure | ☐ Renal Dialysis | ☐ Venereal Disease |
| ☐ Cancer | ☐ Frequent cough | ☐ Hives or Rash | ☐ Rheumatic Fever | ☐ Yellow Jaundice |

# HEALTH HISTORY (CONT.)

Have you ever had any serious illness not listed on previous page? ❑ Yes ❑ No ❑ N/A

Comments: _____

Family Physician's Name _____Telephone _____ Date of Last Physical_____

Cardiologist's Name (if applicable)_____Telephone _____

List all medications you are currently taking (include dose and frequency) _____

To the best of my knowledge, the questions on the form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____

Signature of Patient, Parent, or Guardian Date

# DENTAL HISTORY

Do your gums bleed while brushing or flossing? ○ Yes ○ No

Have you ever had any difficult extractions in the past? ○ Yes ○ No

Have you ever had any prolonged bleeding following extractions? ○ Yes ○ No

Has any dentist mentioned difficulty getting you numb before a procedure? ○ Yes ○ No

Have you ever had any orthodontic treatment? ○ Yes ○ No

Have you ever had periodontal treatment before? ○ Yes ○ No

If yes, please describe what treatment, where, and when. _____

_____

Has your spouse ever had periodontal treatment before? ○ Yes ○ No

Is there a family history of periodontal treatment (siblings, parents) ○ Yes ○ No

Do you wear dentures or partials? ○ Yes ○ No

If yes, please answer the following:

Date of placement: _____

Do you like your dentures or partials? ☐ Yes ☐ No

Are you interested in the advantages of dental implants? ☐ Yes ☐ No

Have you ever had an upsetting dental experience? ○ Yes ○ No

Do you feel nervous about having dental treatment? ○ Yes ○ No

How often do you get your teeth cleaned? _____

Are any of your teeth sensitive to:

Hot or Cold? ○ Yes ○ No

Sweets? ○ Yes ○ No

Biting or Chewing? ○ Yes ○ No

Have you noticed any mouth odors or bad taste? ○ Yes ○ No

Have there been any other sores in your mouth? ○ Yes ○ No

**AUTHORIZATION & RELEASE:** I authorize Dr. Charles Adamo to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to Dr. Charles Adamo insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or behalf of my dependents. I understand that any fees not paid by the insurance company within 60 days of the procedure become my responsibility, and that any fees not paid within 90 days of the procedure are subject to a finance charge.

_____ _____

Signature of Patient, Parent, or Guardian Date

# HIPAA CONSENT

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- ✔ *Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);*
- ✔ *Obtaining payment from third party payers (e.g. my insurance company);*
- ✔ *The day-to-day healthcare operations of this dental practice.*

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Date _____

Print Patient Name _____

Signature _____

Relationship to Patient _____

# FINANCIAL POLICY

We are pleased that you chose our office for your Periodontal and Dental Implant needs. We are committed to providing the highest quality of care for our patients.

**Please read and sign this document prior to your exam. We will provide you a copy for your records if you prefer.*

**Your First Visit:** You will receive a detailed Oral and Periodontal exam (**$60.00**) which includes any x-rays. If you have dental insurance, we will file this claim and the insurance can reimburse you. Dr. Adamo will establish a treatment plan, and then our financial coordinator will explain our fees, expected insurance payments, and the financial arrangement options we offer.

**Successive Visits:** You may undergo procedures such as Scaling & Root Planning (deep cleaning), Periodontal (Gum) Surgery, or Dental Implant Surgery. Payment will be made as arranged at the first visit. If insurance is expected to cover a portion of your treatment fees, you will pay the remainder at this visit and an insurance claim will be filed immediately. Any fees that remain unpaid by your insurance company 60 days after treatment must be paid by the patient (or responsible party).

**Routine Visits:** Periodontal Maintenance visits are necessary after periodontal treatment. Your teeth will be cleaned by our hygienist. The fee for this is $107.00. There is an additional charge for x-rays if necessary. This will be paid at the time of service. If you have dental insurance, we will file a claim so that the insurance company can reimburse you for that visit. We usually recommend an alternate maintenance plan which consists of two cleanings per year at our office and two cleanings per year at your family dentist's office.

**Payment Options:** We will accept cash, personal checks, money orders, CareCredit and most major credit cards (Visa, Mastercard and Discover). Our financial partner, Care Credit, offers no-interest payment plans, subject to credit approval.

_____ _____

Signature Date