



HARKER HEIGHTS 254-680-0223 • WACO 254-754-1456

PATIENT REFERRAL TO CHARLES T. ADAMO, D.D.S., M.S.

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Phone: (254) 754-1456

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frontdesk@adamodentalimplants.com

Date _____

Referring Doctor's Name _____

& Office Phone Number _____

Referral For: Comprehensive Periodontal Exam
 Free Gingival or Connective Tissue Graft
 Dental Implants for teeth #'s _____

Frenulectomy
 Gingivectomy

Zimmer - Custom Duplicate Abutments
 Nobel Biocare Bicon -Short Implant
 Straumann All on 4

Notes / Concerns _____

Patient Information

Name _____ DOB _____ SS# _____

Address _____ City _____ State _____ Zip Code _____

Home Phone () _____ Cell Phone () _____ Work Phone () _____

Insurance Information

Subscriber's name _____ Subscriber's DOB _____

Subscriber's SS# _____

Name of insurance _____ Insurance phone # _____

Employer Insurance is through _____ Policy/Group # _____

X-Rays

Pano: Has your office taken a Pano within the past 12 months?

Yes No If, yes, please mail a copy to us.

PA's: Have you taken any PA's within the past 12 months?

Yes No If yes, please indicate what was taken: _____ and if digital, please email to frontdesk@adamodentalimplants.com (No need to mail hard copies of periapical x-rays).

THANKS!

Please inform your patient that we will contact them within the next 7 days.
If they have not received our message or spoken with us in this time, they should call our office.