Advanced Dental Care
Lama Shoukfeh, DDS

3233 63rd Street, Ste. C • Lubbock, Texas 79413 • 806-794-5280
advanceddentalc@yahoo.com

Patient Information

Patient Name _____ Date of Birth _____ Email _____

Home Address _____ City _____ State _____ Zip Code _____

Social Security # _____ Home Phone # _____ Cell Phone # _____

Employer _____ Address _____ Work Phone # _____

Check Box: Minor _____ Single _____ Married _____ Divorced _____ Widowed _____

If patient is a minor please list:

_____

Parent/Guardian Name **Relationship to Child** **Phone #**

Date of Birth _____ Address _____ City _____ Tx _____ Zip Code _____

Employer _____ Social Security # _____ Work Phone # _____

Physician's Name _____ Phone # _____ Date of Last Physical _____

How did you learn about our office _____ **Referred by** _____

Medical History

Y	N	Conditions	Y	N	Conditions	Y	N	Conditions
☐	☐	Abnormal Bleeding	☐	☐	Heart Surgery	☐	☐	HIV+/Aids
☐	☐	Alcohol Use	☐	☐	Hemophilia	☐	☐	Heart Attack
☐	☐	Allergies	☐	☐	Hepatitis Type _____			
☐	☐	Anemia	☐	☐	High Blood Pressure	☐	☐	Tuberculosis
☐	☐	Angina Pectoris	☐	☐	Kidney Problems	☐	☐	Ulcers
☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐	Venereal Disease
☐	☐	Artificial Heart Valve	☐	☐	Low Blood Pressure	☐	☐	Yellow Jaundice
☐	☐	Artificial Joints	☐	☐	Mitral Valve Prolapse			**Allergies**
☐	☐	Asthma	☐	☐	Osteoporosis	☐	☐	Aspirin
☐	☐	Blood Transfusion	☐	☐	Pace Maker	☐	☐	Codeine
☐	☐	Cancer-Chemotherapy	☐	☐	Pnuemocystitis	☐	☐	Dental Anesthetics
☐	☐	Colitis	☐	☐	Psychiatric Problems	☐	☐	Erythromycin
☐	☐	Cosmetic Surgery	☐	☐	Radiation Therapy	☐	☐	Latex
☐	☐	Diabetes	☐	☐	Rheumatic Fever	☐	☐	Metals
☐	☐	Difficulty Breathing	☐	☐	Seizures	☐	☐	Penicillin
☐	☐	Drug Abuse	☐	☐	Shingles	☐	☐	Sulfa
☐	☐	Epilepsy	☐	☐	Sickle Cell Disease	☐	☐	Tetracycline
☐	☐	Emphysema	☐	☐	Sinus Problems			**Other** _____
☐	☐	Fainting Spells	☐	☐	Stroke			_____
☐	☐	Glaucoma	☐	☐	Thyroid Problems			_____

Please list any medications you are currently taking_____

_____

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If Female: Are you taking birth control _____ Are you Pregnant _____ How many weeks _____ Nursing _____

Is there any disease, condition or problem that you think this office should know about that is not covered on the previous page?

If so, please explain _____

_____

Do you smoke? _____ Preferred Pharmacy _____

Emergency Contact Name _____ Phone # _____

Address _____ Relationship to Patient _____

DENTAL HISTORY

Check All That Apply:

☐ Bleeding gums	☐ Tooth Pain	☐ Trouble Chewing
☐ Bad Breath	☐ History of Fever Blisters	☐ Sensitivity to Hot/Cold
☐ Missing Teeth	☐ Clench or Grind Teeth	☐ Jaw, Head and/or Neck Pain
☐ Frequent Headaches	☐ Sensitivity to Sweets	☐ Jaw Clicking or Popping
☐ Loss Teeth	☐ Broken Teeth or Fillings	☐ Sensitivity when Biting

Former Dentist _____ Date of last X-Rays _____

Date of last dental visit _____ How often do you floss _____

Do you like your smile _____ What would you like to change about your smile _____

_____

Do you snore or have difficulty sleeping _____

DENTAL INSURANCE INFORMATION

Insured Name _____ Date for Birth _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

Phone # _____ Employer _____ Social Security # _____

Insurance Carrier _____ ID # _____ Group # _____

Insurance Address _____ City _____ State _____ Zip _____

By my signature, I acknowledge my Medical History is accurate. I hereby authorize and direct payment of any dental benefits otherwise payable to me, directly to Dr. Lama Shoukfeh. I authorize the use of this signature on all insurance submissions.

_____

Signature of Responsible Party Date

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PATIENT FINANCIAL AGREEMENT

Payment is due at the time of service. If you have dental insurance, it will be filed and you are responsible for the estimated co-pay. Your dental insurance is filed as a courtesy to you and ***all balances not paid by your insurance company therefore become the patient/guarantors' responsibility***. Insurance companies do not guarantee payment when insurance benefits are verified and payment from your insurance company is paid according to their "schedule of allowances", which is not given to our office at the time we inquire about your insurance benefits. Dr. Shoukfeh may or may not be a participating provider with your insurance company, therefore, you may have an additional out of pocket expense after your insurance company has made payment to our office.

I understand:

1. Unpaid fees and expenses for dental services if not paid within ten (10) days from the statement date shall accrue interest at the rate of 18% per annum until paid.
2. A late fee of **$50** per month may be added to my account for all amounts more than **30** days past due.
3. Should I fail to pay my account in full, my account may be sent to a collection agency for nonpayment.
4. Delinquent accounts may be sent to an attorney or have a lawsuit filed.
5. Should my account go to a collection agency or an attorney or should legal action be filed against me for nonpayment, I shall also be liable for all reasonable fees, costs and legal expenses thereby incurred.
6. I waive the receipt of any notices or disclosures otherwise require by law.
7. Venue for any legal action shall be in Lubbock, Lubbock County, Texas.

_____

Patient Signature Date

APPOINTMENT CANCELLATION POLICY

We understand that unplanned issues can come up and you may need to cancel an appointment. We respectfully ask for scheduled appointments to be ***rescheduled or cancelled*** **at least 48 hours in advance**.

Our doctor and hygienist want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses the opportunity to be seen in that allotted time. Circumstances have caused us to enforce a policy of charging for ***no show appointments*** **and for those *not cancelled within* 48 hours**. There will be a fee of ***$50 per missed appointment*****;** will applied to your account if we ***do not*** receive a call to reschedule or cancel an appointment.

Thank you for your understanding and cooperation. This policy will enable us to open otherwise unused appointments to better serve the needs of our patients. We provide our patients with the best possible care and appreciate you choosing to come to Advanced Dental Care for your dental treatment.

I have read and understand the cancellation policy.

_____

Patient Signature Date

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Acknowledgement of Receipt of Notice of Privacy Practices

"You May REFUSE To Sign This Acknowledgement"

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____ _____
Print Name Date

_____ _____
Signature Date

**********For Official Use Only**********

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgment

☐ Other (Please Specify)

_____

_____