Dr. Lewis Specker Jr., D.D.S., Inc.
Dr. Anna Dneprov, D.D.S., M.A.

Patient Information Form

Today's Date _____

Patient's Name: First_____ MI_____ Last_____ Nickname_____

Address: Street_____City_____State____Zip_____
Phone: Home_____ Work _____Mobile_____
E-mail address _____
By providing your e-mail address you agree to receive *(check one or both)* ☐Appointment reminders ☐Practice newsletters
What is your preferred method of contact? ☐Home Phone ☐Work Phone ☐Mobile phone ☐E-Mail
Social Security Number_____**Date of Birth**_____
Drivers License #_____**State**_____
Employer_____ **Occupation**_____**Phone**_____
Address: Street_____City_____State____Zip_____
Sex ☐Male ☐Female **Marital Status** ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed
In case of emergency, who should be notified? _____
Relationship to Patient_____ **Home Phone**_____ **Mobile Phone**_____

Dental Benefit Plan Information

Primary Dental Plan Name_____
Address: Street_____City_____State____Zip_____
Name of Insured _____**Date of Birth** _____ **ID Number**_____
Policy Number _____ **Patient Relationship to Insured**_____
Secondary Dental Plan Name_____
Address: Street_____City_____State____Zip_____
Name of Insured _____**Date of Birth** _____ **ID Number**_____
Policy Number _____ **Patient Relationship to Insured**_____

Medical Benefit Plan Information

Plan Name_____

Address: Street_____City_____State____Zip_____

Name of Insured _____**Date of Birth** _____ **ID Number**_____

Policy Number _____**Patient Relationship to Insured**_____**Deductible**_____

Is the patient a Minor?

☐Yes ☐No **Full-time Student** ☐Yes ☐No **Name of School**_____
Name of Responsible Party: First_____Last_____
Date of Birth _____**Relationship to Patient** ☐Self ☐Spouse ☐Parent ☐Other_____
If Patient is a Minor, Primary Residency ☐Both Parents ☐Mom ☐Dad ☐Step Parent ☐Shared Custody ☐Guardian
Address: Street_____City_____State____Zip_____
Phone: Home_____ Work _____Mobile_____
Employer_____ **Occupation** _____**Phone**_____
Address: Street_____City_____State____Zip_____

Whom may we thank for referring you?

☐One of our valued patients *(name of patient)*_____

☐Internet ☐Our Website ☐Other_____

Please list members of your immediate family who are patients in our practice

_____ _____ _____ _____

Patient Responsibilities: We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with our practice.

Payment: Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. We accept the following forms of payment:
All Major Credit Cards, Checks, Cash
* Please note: If you elect to apply for third-party financing, administered through our practice, we are required by law to provide you with a Credit for Dental Services Notice.

Dental Benefit Plans: Your dental benefit is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are happy to help our patients with dental benefit plans to understand and maximize their coverage.

If we are a contracted provider with your plan, you are responsible only for your portion of the approved fee as determined by your plan. We are required to collect the patient's portion (deductible, co-insurance, co-pay, or any amount not covered by the dental benefit plan) in full at time of service. If our estimate of your portion is less than the amount determined by your plan, the amount billed to you will be adjusted to reflect this.

If we are not a contracted provider with your dental benefit plan, it is the patient's responsibility to verify with the plan whether the plan allows patients to receive reimbursement for services from out-of-network providers. If your plan allows reimbursement for services from out-of-network providers, our practice can file the claim with your plan and receive reimbursement directly from the plan if you "assign benefits" to us. In this circumstance, you are responsible and will be billed for any unpaid balance for services rendered upon receipt of payment from the plan to our practice, even if that amount is different than our estimated patient portion of the bill. If you choose to not "assign benefits" to our practice, you are responsible for filing claims and obtaining reimbursement directly from your dental benefit plan and will be responsible for payment to our practice before or at the time of service.

Scheduling of Appointments: We reserve the doctor and hygienist's time on the schedule for each patient procedure and are diligent about being on-time. Because of this courtesy, when a patient cancels an appointment, it impacts the overall quality of service we are able to provide. To maintain the utmost service and care, we do require 48-hour notice to reschedule an appointment. With less than 48-hour notice, a fee of $30 may be applied. To serve all of our patients in a timely manner, we may need to reschedule an appointment if a patient is fifteen minutes late or more arriving to our practice.

Authorizations: I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment. _____**(initial)**

I have read the above and agree to the financial and scheduling terms._____ **(initial)**

I authorize the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to this doctor otherwise payable to me. ☐YES ☐NO *(Check One)* _____**(initial)**

I hereby acknowledge that a copy of this practice's **Notice of Privacy Practices** has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice. _____**(initial)**

I hereby acknowledge that a copy of this practice's **Dental Materials Fact Sheet** has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet. _____**(initial)**

Signature_____ **Date**_____

Dr. Lewis Specker Jr., D.D.S., Inc.
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Dental Health History Form

Today's Date _____

Patient's Name: First_____ MI_____ Last_____ Nickname_____

Are you experiencing any dental pain now? ☐ Yes ☐ No
If yes, please describe_____

What are your goals in coming to our practice today? _____
What is important to you in a dentist or dental practice? _____
What has been your experience with dentist in the past? _____

Date of last radiographs (x-rays) and exam _____
Date of last hygiene continuing care appointment *(cleaning or periodontal maintenance)* _____

Former dentist _____**Phone**_____
Address: Street_____City_____State____Zip_____
If you left your previous dentist, what are the reasons?_____

Have you had problems with prior dental treatment? _____

Have you ever been pre-medicated for dental treatment? ☐ Yes ☐ No
If yes, why? _____

Have you been anxious about having dental treatment? ☐ Yes ☐ No
If yes, would you be comfortable sharing why? _____

What concerns do you currently have with your oral health or smile? *(Check all that apply)*

- ☐ Jaw joint pain
- ☐ Clenching or grinding of teeth
- ☐ Discolored teeth
- ☐ Crowding/crooked teeth
- ☐ Missing teeth
- ☐ Spaces in between teeth
- ☐ Loose tooth/teeth
- ☐ Tooth shape or size
- ☐ Unhappy with appearance of teeth
- ☐ Overbite
- ☐ Underbite
- ☐ Uncomfortable bite
- ☐ Old fillings (gold or silver)
- ☐ Old crowns
- ☐ Speech problems
- ☐ Too much gum tissue when I smile
- ☐ Tooth sensitivity to hot/cold or anything else
- ☐ Food get caught in between teeth
  If yes, where? _____
- ☐ Difficulty chewing
  If yes, where? _____
- ☐ Bad breath
- ☐ Other_____

Have you ever had orthodontic treatment? ☐ Yes ☐ No
If yes, when? _____

Have you ever had periodontal (gum tissue) treatments, such as deep cleanings, root planning, or periodontal surgery?
☐ Yes ☐ No **If yes, when?** _____

Have you whitened your teeth in the past? ☐ Yes ☐ No **If yes, what method?**_____

Are you interested in learning more about the following? *(Check all that apply)*

- ☐ Teeth Whitening
- ☐ Orthodontic treatment
- ☐ Invisalign
- ☐ Veneers
- ☐ Tooth colored fillings
- ☐ Dental implants
- ☐ How to prevent periodontal disease
- ☐ At-home oral hygiene care
- ☐ Periodontal treatment during pregnancy
- ☐ Oral hygiene care for infants and toddlers

Dr. Lewis Specker Jr., D.D.S., Inc.
Dr. Anna Dneprov, D.D.S., M.A.

Confidential Medical Health History Form

Today's Date _____

Patient's Name: First_____ MI_____ Last_____ **Date of Birth**_____

I. Circle appropriate answer *(Leave blank if you do not understand the question)*

1. ☐Yes ☐No **Is your general health good?**
   If NO, explain_____
2. ☐Yes ☐No **Has there been a change in your health within the last year?**
   If YES, explain_____
3. ☐Yes ☐No **Have you gone to the hospital or emergency room or had a serious illness in the last three years?**
   If YES, explain_____
4. ☐Yes ☐No **Are you being treated by a physician now?**
   If YES, explain_____
   Date of last medical exam? _____**Reason for exam**_____

II. Have you experienced any of the following? *(Please check Yes or No for each)*

☐Yes ☐No Chest pain (angina)	☐Yes ☐No Blood in stools	☐Yes ☐No Frequent vomiting
☐Yes ☐No Fainting spells	☐Yes ☐No Diarrhea or constipation	☐Yes ☐No Jaundice
☐Yes ☐No Recent significant weight loss	☐Yes ☐No Frequent urination	☐Yes ☐No Dry mouth
☐Yes ☐No Fever	☐Yes ☐No Difficulty urinating	☐Yes ☐No Excessive thirst
☐Yes ☐No Night sweats	☐Yes ☐No Ringing in ears	☐Yes ☐No Difficulty swallowing
☐Yes ☐No Persistent cough	☐Yes ☐No Headaches	☐Yes ☐No Swollen ankles
☐Yes ☐No Coughing up blood	☐Yes ☐No Dizziness	☐Yes ☐No Joint pain or stiffness
☐Yes ☐No Bleeding problems	☐Yes ☐No Blurred vision	☐Yes ☐No Shortness of breath
☐Yes ☐No Blood in urine	☐Yes ☐No Bruise easily	☐Yes ☐No Sinus problems

III. Have you had or do you have any of the following? *(Please check Yes or No for each)*

☐Yes ☐No Heart disease	☐Yes ☐No Surgeries	☐Yes ☐No Thyroid disease
☐Yes ☐No Family history of heart disease	☐Yes ☐No Hospitalization	☐Yes ☐No Asthma
☐Yes ☐No Heart attack	☐Yes ☐No Diabetes	☐Yes ☐No Hepatitis
☐Yes ☐No Artificial joint	☐Yes ☐No Family history of diabetes	☐Yes ☐No Sexual transmitted disease
☐Yes ☐No Stomach problems/ulcers	☐Yes ☐No Tumors or cancer	
☐Yes ☐No Heart defects	☐Yes ☐No Chemotherapy	☐Yes ☐No Herpes
☐Yes ☐No Heart murmurs	☐Yes ☐No Radiation	☐Yes ☐No Canker or cold sores
☐Yes ☐No Rheumatic fever	☐Yes ☐No Arthritis, rheumatism	
☐Yes ☐No Skin disease	☐Yes ☐No Emphysema/lung disease	☐Yes ☐No Anemia
☐Yes ☐No Hardening of arteries	☐Yes ☐No Kidney or bladder disease	☐Yes ☐No Liver disease
☐Yes ☐No High blood pressure	☐Yes ☐No Stroke	☐Yes ☐No Eye disease
☐Yes ☐No Seizures	☐Yes ☐No Eating disorders	☐Yes ☐No Transplants
☐Yes ☐No Cosmetic surgery	☐Yes ☐No Osteoporosis	☐Yes ☐No Tuberculosis

This information will not be released unless specifically authorized by patient.

☐Anxiety ☐Depression ☐Treatment for emotional condition ☐Contagious diseases or disabilities

IV. Are you allergic to or have you had a reaction to any of the following? *(Please check Yes or No for each)*

☐Yes ☐No Aspirin	☐Yes ☐No Valium	☐Yes ☐No Tetracycline
☐Yes ☐No Darvon	☐Yes ☐No Demerol	☐Yes ☐No Vicodin
☐Yes ☐No Codeine	☐Yes ☐No Penicillin	☐Yes ☐No Percodan
☐Yes ☐No Latex	☐Yes ☐No Food	☐Yes ☐No Nitrous oxide
☐Yes ☐No Local anesthetic (Novocain or Xylocaine)	☐Yes ☐No Erythromycin	☐Yes ☐No Metal

Others_____

V. Are you taking or have you taken any of the following in the last three months? *(Please check Yes or No for each)*

☐Yes ☐No Recreational drugs	☐Yes ☐No Tobacco in any form	☐Yes ☐No Antibiotics
☐Yes ☐No Over-the-counter medicines	☐Yes ☐No Alcohol	☐Yes ☐No Supplements
☐Yes ☐No Weight loss medications	☐Yes ☐No Bisphosphonate	☐Yes ☐No Aspirin
☐Yes ☐No Cortico - Steroids	(Fosamax/Boniva)	

Please list all medications you are currently taking_____

VI. Women only *(Please check Yes or No for each)*

☐Yes ☐No Are you or could you be pregnant? If YES, what month?_____

☐Yes ☐No Are you nursing?

☐Yes ☐No Are you taking birth control pills?

VII. All patients *(Please circle Yes or No for each)*

☐Yes ☐No **Do you have or have you had any other diseases or medical problems NOT listed on this form?**
If YES, explain_____

☐Yes ☐No **Have you ever been pre-medicated for dental treatment?**
If YES, why_____

☐Yes ☐No **Have you ever taken Fen-Phen?** If YES, when_____

☐Yes ☐No **Is there any issue or condition that you would like to discuss with the dentist in private?**

If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.
I authorize the dentist to contact my physician.

Patient's Signature_____ Date_____
Physician's Name_____ Phone Number_____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____	_____	_____	_____
Signature of Patient (Parent or Guardian)	Date	Signature of Dentist	Date

Medical updates

I have reviewed my Health History and confirm that it accurately states past and present conditions.

Date	Patient Signature	Changes to Health History	Dentist Initials
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

DR. LEWIS SPECKER, D.D.S.
DR. ANNA DNEPROV, D.D.S.
180 Montgomery Str, Ste 2460, San Francisco, CA 94104
Telephone: (415) 982-7443 Fax: (415) 362-1321

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

NAME:_____

Section B: TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

PURPOSE OF CONSENT: By signing this form, you will consent to our use and disclosure or your protected health information to carry out treatment, payment, activities, and healthcare operations.

You may obtain a copy of our notice of Privacy Practices including any revision of our Notice, at any time by contacting:

Contact: Lewis Specker, D.D.S., Anna Dneprov, D.D.S.,
180 Montgomery Str, Ste 2460
San Francisco, CA 94104
Telephone: 415-982-7443
Fax: 415-362-1321
Email: info@drspecker.com
Website: www.DrSpecker.com

Right to revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the office listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

Signature: _____ Date: _____

If this consent is signed by a personal representative on behalf of the patient, please complete the following:

Personal representative's name: _____ *Date:* _____

Relationship to patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

DR. LEWIS SPECKER, D.D.S.
DR. ANNA DNEPROV, D.D.S.
180 Montgomery Str, Ste 2460, San Francisco, CA 94104
Telephone: (415) 982-7443 Fax: (415) 362-1321

FEES AND PAYMENTS

We make every effort to keep down the cost of your dental care. **You can help by paying upon completion of each visit.** Other arrangements can be made with our Office Manager depending upon special circumstances. An estimate of charges for any procedures or surgery you may require will be given to you after each consultation, and/or upon request. If you have dental or medical insurance we will be glad to fill out the proper forms. Please complete all identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and not a substitute for payments. Some companies pay fixed allowance for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amounts, co-insurance or any other balance not paid for by your insurance company.**

I certify that I have read and I understand the policies above. I acknowledge that my questions, if any, about the policies set forth above have been answered to my satisfaction, I will not hold Dr. Specker/Dr. Dneprov, or any other member of the staff, responsible for any error or omissions that I have made in the completion of this form.

Subscriber's Name: _____

Address: _____ City: _____State: _____ Zip:_____

Primary Insurance: _____

Address: _____ City: _____State: _____ Zip:_____

Group #: _____ ID#: _____ SSI#:_____

Patient Signature:_____Date_____

Reviewed by: _____Date_____

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment of benefits to Dr. Specker/Dr. Dneprov.

Patient Signature:_____ Date_____