PENNSYLVANIA CENTER
for Dental Excellence

Leonard F. Tau, DMD

On behalf of the entire team at the Pennsylvania Center for Dental Excellence, let me welcome you to our practice. We are grateful that you have chosen us to meet your dental needs, and trust that you will find your experience in our office to be pleasant, professional, and extraordinary.

You may discover that we are different from the average dental practice. When you visit our office you will find a unique and relaxing environment. Our team is friendly and attentive. All of our treatment is designed to be comfortable, to be long lasting, and to exceed all your expectations. We use the latest technology and techniques our profession has to offer. Our greatest strength lies in the unequaled advanced training in cosmetic and reconstructive dentistry we have received. It is for these simple reasons that we are the "Pennsylvania Center for Dental Excellence."

In order to better serve you, we are enclosing in this Welcome Packet several important documents that will assist us in making your transition to our office as smooth as possible. Please read each one carefully so that you can become familiar with our practice philosophy and policies. We are happy to answer questions you may have at any time.

Please find the enclosed questionnaire that should be filled out prior to your first appointment with Dr. Tau.

Be sure to visit our website at *www.pcde.com*. We look forward to serving all your dental needs for you and your family.

Yours truly for better dental health,

Leonard F. Tau, DMD

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REGISTRATION AND HEALTH HISTORY

Date: _____

First Name: _____ M.I. ____ Last Name: _____ ☐ male ☐ female Date of Birth: _____ (Enter as MM/DD/YYYY) Age: ____

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

Home Phone: _____ Work Phone: _____ Cell Phone: _____ Social Security#: _____ (Do NOT include dashes or spaces)

Email Address: _____ Emergency Contact: _____

Marital Status: ☐ Married ☐ Single Student: ☐ Full-time ☐ Part-time ☐ N/A Occupation: _____

What would you prefer to be called? _____ Who may we thank for this referral? _____

Family Physician: _____ Phone#: _____

Dental Insurance Carrier: _____ ID#: _____ Group #: _____

☐ Check this box ***ONLY*** if the Insured person *(the person receiving dental service)* is the same as applicant above. If not, enter Insured info below.

Name of Insured: _____ Insured's SS#: _____ (Do NOT include dashes or spaces) Insured's Date of Birth: _____ (Enter as MM/DD/YYYY)

Relationship to Insured: _____

Employer of Insured: _____ ☐ Full-time ☐ Part-time ☐ Retired Phone#: _____

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

Who is financially responsible for this account? _____ Phone#: _____

Please select Y = Yes or N = No if you have any of the following conditions:

☐ Y ☐ N - Rheumatic Fever	☐ Y ☐ N - Thyroid Disease	☐ Y ☐ N - Seizure Disorder
☐ Y ☐ N - Heart Disease	☐ Y ☐ N - Anemia	☐ Y ☐ N - Kidney Disease
☐ Y ☐ N - Heart Murmur (or MVP)	☐ Y ☐ N - Asthma	☐ Y ☐ N - Venereal Disease
☐ Y ☐ N - High Blood Pressure	☐ Y ☐ N - Diabetes	☐ Y ☐ N - Bleeding Problems
☐ Y ☐ N - Tuberculosis	☐ Y ☐ N - Are you nursing	☐ Y ☐ N - Cancer
☐ Y ☐ N - Use Oral Contraceptives	☐ Y ☐ N - Might you be pregnant	☐ Y ☐ N - Aids/HIV
☐ Y ☐ N - Artificial Joint / Heart Valve	☐ Y ☐ N - Hepatitis Type: ☐ A ☐ B ☐ C	☐ Y ☐ N - Eating Disorders
☐ Y ☐ N - History of Endocarditis	☐ Y ☐ N - Radiation Therapy: Head / Neck	☐ Y ☐ N - History of HPV

Other conditions not listed: _____

Are you allergic to latex, soy, egg, milk, dairy or nuts products? _____

List any antibiotics, anesthetics or other drugs you are allergic to: _____

List all prescription/OTC medications, vitamins and/or supplements you are presently taking: _____

_____

Do you have any disease, organ transplant, or take any medication which may depress your immune system? _____

Do you have, or have you ever had clicking, popping or pain in your tempromandibular joints (TMJ)? _____

Have you been hospitalized in the past five years? ☐ Yes ☐ No If yes, why? _____

Do you take aspirin on a daily basis? ☐ Yes ☐ No If yes, why? _____

Are you under a physician's care presently? ☐ Yes ☐ No If yes, why? _____

Have you ever been a drug or substance abuser? ☐ Yes ☐ No Do you smoke? ☐ Yes ☐ No How much? _____

Is there anything you would like to discuss with the Doctor in private? _____

I attest that I understand and answered all the above questions honestly and completely. I understand that the doctor is basing his treatment on this information. I authorize the release of information to insurance carriers and other health care professionals who are involved in my care. I assign my insurance benefits to PCDE unless otherwise indicated.

Signature: _____ **Date:** _____

*Your signature indicates you have received a copy of the HIPAA law and Dental Materials forms as well as releasing Dr. Tau to utilize any dental photographs for lecturing and educational purposes.

Have you seen us on: ☐ Facebook ☐ Twitter ☐ YouTube ☐ Google Reviews ☐ Television ☐ Local Magazine

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DENTAL HEALTH AND APPEARANCE

Reason for visit: _____ Approximate date of last dental visit: _____

What is your primary concern that you would like us to address first? _____

When would you like us to start treatment? _____

Have you ever had any serious problem associated with previous dental treatment or any dental emergencies? ☐ Yes ☐ No

If so, explain: _____

What, if anything, has happened in previous experiences at the dentist that was reason not to return? _____

_____

Do you ever feel (or have you ever been told) that you don't have fresh breath? _____

How often do you brush your teeth? ____ time(s) a select... How often do you floss? ____ time(s) a select...

What type of brush do you use? ☐ Manual ☐ Powered

Do you avoid brushing any part of your mouth because of pain? ☐ Yes ☐ No If yes, what part? _____

Which foods cause you twinges of pain: ☐ Hot ☐ Cold ☐ Sweet ☐ Sour ☐ None

Do your gums feel tender or swollen? ☐ Yes ☐ No

Do you chew on only one side of your mouth? ☐ Yes ☐ No If yes, explain: _____

Do you clench or grind your jaws while sleeping or during the day? ☐ Yes ☐ No Do your jaws ever feel tired? ☐ Yes ☐ No

COSMETIC/ESTHETIC EVALUATION

Are you delighted with your smile? ☐ Yes ☐ No Please rate your smile from 1 to 10 (1 = I hate my smile, 10 = Awesome): ____

Would you like to have whiter teeth? ☐ Yes ☐ No

If you had a magic wand, what, if anything, would you change about your smile? _____

What (if any) personal or professional benefit might you gain if you had a gorgeous smile? _____

Do you have any special occasions coming up? _____

Through state-of-the-art technology of cosmetic dentistry, we have the ability to help you achieve a world-class smile, often overnight using Dental Imaging and Digital Photography, we can simulate very closely how YOU would look after the improvements, PRIOR to any treatment! Imaging can be performed as part of your exam visit (at NO additional charge). Would you like to see what YOU would look like with a new and improved smile? ☐ Yes ☐ No **If yes, please select all that apply:**

☐ Lighten all front teeth showing	☐ Rebuild fracture(s)	☐ Straighten rotation	☐ Eliminate dark or stained fillings
☐ Lighten single tooth	☐ Lengthen	☐ Straighten angulation	☐ Reduce gum showing in smile
☐ Close spaces between teeth	☐ Shorten	☐ Eliminate crowding	☐ Repair uneven edges

Please add anything you feel is important:

At Pennsylvania Center for Dental Excellence, though our focus is on appearance-related dentistry, our team also delivers routine general dental care as well. With flexible payment plans as well as phasing treatment over time, you and your family can achieve spectacular long-term results. Thank you so much for the opportunity to be of service.

Warm Regards,
Leonard F. Tau, DMD

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please ***print*** name of Patient Please ***sign*** for Patient/Guardian of Patient

_____ _____

Legal Representative/Guardian Relationship of Legal Representative/Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Sir Name ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message
☐ Text Message
☐ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ☐
I could not communicate with the patient ☐
The patient refused to sign ☐
The patient was unable to sign because ☐
Other (please describe) ☐

_____
Signature of Privacy Officer

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FINANCIAL MENU

We are committed to providing you with the best dental care. Our fees reflect our professional commitment to excellence. If you have dental insurance, we are happy to help you receive your maximum allowable benefit. In order to achieve these goals,we need your assistance and your understanding of our payment policy. For your convenience we offer a wide range of financial options in order to pay for your dental treatment:

A) Split Payment

Half of the total treatment is due at the preparation visit, and the second half is due the day of cementation of the crowns/bridges/veneers.

B) Pay as You Go

You may choose to pay your obligation for each visit with cash, check, or credit card at the visit.

C) Prepayment in Full

For any treatment over $2000, a prepayment Bookkeeping Courtesy of 5% will be given for direct payment in full by cash or check before or at the first treatment visit.

D) CareCredit

Care Credit offers No Interest financing for up to 24 months and low monthly payment options. There are no up front costs, no prepayment penalties and no fees as long as it is paid in full by the end of the term. This allows you to get the necessary work done now and pay later.

FORMS OF PAYMENT ON BALANCES DUE

In order to facilitate access to the very best dental care possible, you may choose from any of the following: Cash, Visa, MasterCard, American Express, Discover, Personal Checks or Care Credit (see above).

Interest of 1.5% per month will be charged on any unpaid balance after 60 days. This allows sufficient time for your insurance carrier to make payment. By law, insurance companies are required to make payment or deny a claim within 30 days. Please be aware that your dental benefit program is a contract between you, your employer and the insurance company. We are not a party to that contract. We file insurance claims as a courtesy to you, our valued patient. You are responsible (not your insurance company) for all feed for services rendered. We will gladly assist you in any way we can.

I understand that if I become delinquent on my account, my account will be turned over to a collection agency and I will subsequently be reported to the credit bureaus. In case of total default I agree to pay all costs for collection including but not limited to interest, court costs, sheriff fees, attorney fees and collection costs that may be incurred to collect on this account.

Please be aware that any parent or guardian bringing a child to our office is legally responsible for the payment of services rendered.

After your dental insurance has paid for dental services rendered at PCDE, you may have an outstanding balance. This balance may include any deductibles, copayments, denials, and non-covered services. We do our best to estimate what you will owe. For balance owed, we will require a credit card authorization, or you may need to pay your entire balance up-front.

Credit Card: (check one): ☐ Visa ☐ MasterCard ☐ Discover ☐ Amex ☐ CareCredit

Card#:_____ Expiration Date:_____ CVV #:_____

(Do NOT include dashes or spaces) *(Enter as MMYY)*

Card Holder Signature:_____

Billing Address:_____ State:_____ Zip:_____

I certify that I have read, fully understand, and accept the above financial policy.

Signature: _____ **Date:** _____

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COMFORT MENU

Your comfort is our priority. We provide a variety of services to ensure that you are comfortable at all times. Please select from the following options:

- Patients find that if they take an analgesic prior to treatment it helps later in the day.
  Which would you prefer? ☐ Tylenol ☐ Advil ☐ Other: _____

- We provide various levels of sedation to ease your mind.
  Would you benefit from a sedative?..... ☐ Yes ☐ No

  If yes, we provide: ☐ Nitrous Oxide (laughing gas)
  ☐ Mild sedative (oral medication
  (Note: With mild sedative, you will need someone to drive you to the appointment.)

- We now offer Oraverse, Oraverse is the first and only product to rapidly reverse the effects of your local dental anesthetic.
  Would you be interested in learning more about it?..... ☐ Yes ☐ No

- Our treatment rooms are equipped with cable TV and DVD players. Watching TV or a movie is an excellent way to pass the time during your visit. Please let us know what your favorite movie or TV shows are, and at your next appointment we will make sure we have it for you to watch.

- We also have iPods for your use with personalized playlists.
  Would you like to use an iPod during your visits?..... ☐ Yes ☐ No
  Please provide a list of the artists or type of music you like so we can load them for your next visit.

- Complimentary WiFi Internet access is available for your use throughout the office. Please feel free to bring your wireless Internet device with you for each visit.

- Blankets help keep you warm and relaxed through your visit.
  Would you like a blanket?..... ☐ Yes ☐ No

- Pillows provide an extra measure of comfort if you have a sore back or neck.
  Would you like a pillow?..... ☐ Yes ☐ No

- We also offer our patients a complimentary paraffin wax treatment during your visit.
  Would you like to take advantage of this service?..... ☐ Yes ☐ No

- Is there anything else we can do to make your visit comfortable?

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Please Handle Me With Care

_____

Patient Name

We feel it is necessary to develop a rapport with our patients. Many new patients have had a past unpleasant dental experience. It is crucial to us to know and understand your concerns. We are committed to taking the time to get to know you, discuss your concerns, your fears, and your dental expectations.

Please place a check mark in the box next to the statement that concerns you or describes your problem.

- ☐ I gag easily.
- ☐ I feel out of control when I'm lying down for a long time, and I feel uncomfortable about what you will say about my teeth and hygiene.
- ☐ Pain relief is a top priority for me.
- ☐ I don't like shots (or I've had a bad reaction to shots).
- ☐ Please tell me what I need to know about my mouth in order to make an informed decision.
- ☐ My teeth are very sensitive.
- ☐ I don't like the sound of that tool that makes the picking and scraping noise. It is like someone is scratching fingernails on a blackboard.
- ☐ I don't like cotton in my mouth.
- ☐ I hate the noise of the drill.
- ☐ Please respect my time. I don't want to be left sitting in the reception area.
- ☐ I want to know the cost up front.
- ☐ I have difficulty listening and remembering what I hear while sitting in the dental chair.
- ☐ I have health problems and questions that we need to discuss.
- ☐ I am interested in conscious sedation (nitrous oxide with oxygen)
  (Commonly called laughing gas, produces a mild sedation that is helpful in decreasing anxiety.)
- ☐ I am interested in oral sedation: for adults who need a deeper state of sedation

Partnership Pact:

I ask that you honestly inform me of all my dental problems. I want you to make me aware of the best quality dentistry available today. Then we can discuss how I can make healthy choices that will work within my budget. I also want to know all the pain relief options available to me, how each dental procedure will work, and how much of my time will be required.

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APPOINTMENT AGREEMENT

At the Pennsylvania Center For Dental Excellence, we understand that your time is very valuable. We are constantly striving to make your experience here more pleasant than any other place you have previously been. Trying to accommodate every patient's individual needs and work schedule can be challenging. We make every effort to stay on time so that our patients will not have to wait unnecessarily.

Your appointment is a commitment of time between you and our office. We ask that you make every effort to keep that commitment. We do provide a courtesy reminder call one to two days prior to your appointment.

If you find that you cannot keep your appointment, we do require a minimum notice of 24 business hours so we are able to assist other patients with their dental needs. If our office is not notified within the 24 business hours, you will be subject to a $50 late cancellation charge.

By signing below, I agree to fulfill my obligation as a patient at the Pennsylvania Center For Dental Excellence and agree to the "broken appointment" fee should I not give proper notification.

Signature of Patient or Responsible Party **Date**

PENNSYLVANIA CENTER for Dental Excellence

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Completion Instructions

Thank you for taking the time to complete our New Patient Welcome Packet. If everything is correct, please print pages 2 - 7 and bring them in on your first appointment visit. Alternatively, you may submit this entire packet electronically to PCDE by pressing the "**Submit via E-mail**" button below and following the on-screen instructions.

After successfully printing the document and verifying that everything is correct and fully complete (or after successful e-mail transmission), you may erase all form content by pressing the reset button below. Or, you may delete the entire file from your computer, if saved.

If you have questions regarding these instructions, please contact our office at (215) 969-4400.

Thank you,
Leonard F. Tau, DMD

Print Form

Submit via E-mail

NOTE: Before resetting this document, please make sure you have a correct and fully completed printed copy.
(Resetting document will permanently erase all entered data!)

Reset Form