Accent Dental LLC

2002 S. ROUSE ST • PITTSBURG, KS 66762 (620)231-2871

Patient Information

Social Security # * ______________

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart#: ______________
FOR OFFICE USE ONLY

Patient Name: ______________ (Last) ______________ (First) ____ (MI) ______________ (Preferred Name)

Title: __________ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: __________ **Prev. Visit:** __________ **Email Address:** ______________

Phone: __________ (Home) __________ (Mobile) __________ (Work) ______ (Ext) **Best time to call:** ______________

Address: ______________ (Address 1) ______________ (Address 2)

______________ (City) ______ (State) _____-____ (Zip Code)

Preferred appointment times:

☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Fri ☐ Sat ☐ Morning ☐ Afternoon ☐ Evening ☐ Any time

Whom may we thank for referring you to our practice?

☐ Dental Office ☐ Yellow Pages ☐ Internet ☐ Newspaper ☐ School ☐ Work
☐ Insurance ☐ Other (name below):

Name of person, office, or other source referring you to our practice:

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Spouse or Responsible Party Information

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: ______________ ______________ ____ ______________
Last First MI Preferred Name

Title: __________ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: __________ **Email Address:** ______________

Phone: __________ __________ __________ ______ **Best time to call:** __________
Home Mobile Work Ext

Address: ______________ ______________
Address 1 Address 2

______________ ______ _____-____
City State Zip Code

Social Security # * __________

Employment Information

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: ______________ **Phone:** __________

Employer Address: ______________ ______________
Address 1 Address 2

______________ ______ _____-____
City State Zip Code

Primary Insurance Information

Primary Dental Insurance:

Name of Insured: ______________________ ______________________ ____
Last First MI

Insured's Birth Date: ____________ **ID #:** ____________ **Group #:** ____________

Insured's Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

Insured's Employer Name: ______________________

Employer Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: ______________________

Insurance Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

Primary Medical Insurance:

Name of Insured: ______________________ ______________________ ____
Last First MI

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: ______________________

Secondary Insurance Information

Secondary Dental Insurance:

Name of Insured: ______________________ ______________________ ____
Last First MI

Insured's Birth Date: ____________ **ID #:** ________________ **Group #:** ____________

Insured's Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

Insured's Employer Name: ______________________________

Employer Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: ______________________________

Insurance Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

Name of Insured: ______________________ ______________________ ____
Last First MI

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: ______________________________

Office Policy

Patients who have failed to keep scheduled appointments without 24 hours notice will no longer be rescheduled. Patients will be given two chances for no show/cancellation before they will be discharged as non-compliant and referred elsewhere for services

Consent for Treatment

I wish to be treated by Accent Dental LLC for health care services. I understand services are available to me without discrimination prohibited by federal and state law. I understand that health related services may be provided by employees, agents and independent contractors utilized by Accent Dental LLC to be contrary in writing, with the understand that the student's work will be under the supervision of a qualified instructor or staff of Accent Dental LLC. While a patient of Accent Dental LLC, I hereby consent to care and treatment, including but not limited to diagnostic and therapeutic testing and treatments may be deemed necessary or advisable by my care provider, his/her associates, or designees, Accent Dental LLC and its employees, based on his/her medical knowledge and my health condition including access to external medication history. I understand that no guarantees have been made to me about the outcome of this care.

If I cannot accompany my child to Accent Dental LLC, I authorize the following to give consent for treatment, which may be required during my absence.
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Release of Information

Accent Dental LLC may disclose all or any part of the patient's medical record to any person or corporation which is or may be liable under a contract for all or part Accent Dental LLC's charges, including but not limited to insurance companies, worker's compensation carriers, welfare agencies or patient's employers. With my signature, I certify that I have read the above information or had it read to me, that I am the patient or am authorized to sign for the patient, and that I accept the above conditions for treatment. A copy of this form will be provided to me should I request one.

Consent to Share Health Information

I am requesting and allowing Accent Dental LLC to discuss/share health information about me with the following *

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Financial Information

Financial Agreement: I hereby assign to Accent Dental LLC any and all medical/dental benefits payable from any policy of insurance covering the patient or person responsible for the patient's care (including by not limited to Medicaid, Blue Cross/ Blue Shield, Delta Dental, etc.) to be paid directly to Accent Dental LLC to be applied to the charges for services rendered. I understand I am responsible for co-insurance payments, deductibles and/or any remaining balance. In the event pre-authorization for such treatment is required by any dental plan or insurance policy, the undersigned patient or agent is responsible for obtaining such pre-authorization.
Medicare/Medicaid Non-Covered Services: I understand that Medicare/Medicaid does not pay for some services such as dental fillings, crowns, bridges, or dentures. I also understand that I am fully responsible for payment of this service.
Thank you for choosing Accent Dental LLC. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.
Payment is due in full at each appointment. For your convenience we offer the following methods of payment please:
- Cash, Check, MasterCard, Discover Card, Visa, or
- NO INTEREST payment plans from CareCredit
o Allow you to pay over time with NO INTEREST
o Convenient, low monthly payment plans also available
o No annual fees or pre-payment penalties

Please note:
Accent Dental LLC requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.
For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.
If payment is not made as agreed, patient shall be responsible for any and all interest ($350 fee), reasonable attorney fees, costs of collection, and court costs incurred in efforts to enforce this agreement.
Accent Dental LLC charges $30.00 for returned checks.

☐ ***In consideration of goods and/or services rendered pursuant to this agreement, do hereby personally, individually, and guarantee the full payment of all sums of money due and owing to Accent Dental LLC. In addition, any sums of money that may become due and owing or past due according to the terms of this agreement; shall be my responsibility.**

Pediatric Patient Information

Our goal at Accent Dental, L.L.C is to provide the utmost in quality care to our patients in a relaxed environment.
We strive to effectively and efficiently perform treatment for your child and instill in them a positive dental attitude.
To accomplish good dental treatment and educate your child, it is mandatory that the Teacher/Student roles be established and maintained during all dental visits. Therefore, it is our policy that parents remain in the waiting room during all treatment.
To achieve our goals, your child's cooperation is essential. We use communicative management methods such as voice control, Tell-Show-Do, Positive reinforcement, distraction, non-verbal communication, and at times, the Hand-Over-Mouth technique. We Do NOT use restraints and at times may feel it necessary to refer your child to a specialist.

I request and authorize Dr. Minnis, and/or staff of Accent Dental, L.L.C. to perform or assist in the performance of dental treatment for the above-named child.

Relationship to Patient:

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By providing my electronic signature below I agree to the above statements.
I agree that all information entered above is accurate to the best of my knowledge.

Please enter your fulll legal name below: *

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Response Date: ____________