TIME 03:35 PM DATE 6/25/2025

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

E-mail Address

Phone Number

Employer

Emergency Contact

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Time 3:33 PM | Garrett Taylor, D.D.S. | Date 6/25/2025

Eaglesoft Medical History

Patient Name: | Birth Date: | Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
						Yellow Jaundice	◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____



Financial Policy and Agreement

At Taylor and Carter Family Dentistry, we value you as a patient. In order to provide exceptional service to all our patients, timely payment of your account is crucial. You have the power to avoid the following penalty by discharging your debt with our office when it is due.

Full payment for all services, whether for the responsible party or anyone on their account, is due at or before the visit. There are times when a planned treatment need may be altered during the course of treatment. Treatment will be suspended, options discussed with the patient, new course of action chosen and continued according to the treating dentist's time and capability. This alteration and its associated fees, once discussed with the patient, will be the responsibility of the patient or responsible party and will be due at the time of service. In the event of a minor receiving treatment without the responsible party present, the responsible party will be required to come to our office for any documentation or consent to treat and payment for treatment prior to the minor being seen.

If you fail to pay your account in full or if satisfactory payment arrangements are not timely made and timely payments are not made pursuant to the payment arrangement within 45 days following your default, we will refer your account to a collection agency.

We accept cash, credit/debit cards and CareCredit. All forms of payment including credit/debit cards and CareCredit cards must be presented for payment on the day of service. A returned check fee of $35.00 will be applied for any returned check.

Any outstanding balances in a family's account must be paid before another appointment can be scheduled unless prior arrangements have been made.

In the event a collection agency is hired to collect any outstanding amount, you agree to pay a collection fee in the amount of forty percent (40%) of the outstanding balance. You will be responsible for paying the collection fee that the collection agency charges for the collection of your debt and that collection fee of forty percent (40%) will be added to your debt and collected by the collection agency. By signing below, you understand and agree to pay that collection fee.

Also, please understand that by signing this agreement in the space provided for you below, you also agree to be solely responsible to pay the other collection fees incurred by Taylor and Carter Family Dentistry and/or its assignee that are collection fees for court costs – such as filing fees, recordation fees, service of process fees and attorney's fees,

which may be awarded by the Court, all of which are associated with the collection of your debt.

Your appointment time is reserved specifically for you. We allow that time to give you the attention needed for your treatment. If you fail to come to your appointment or do not cancel 48 hours in advance of your appointment, your account may be charged a $50.00 fee. This is a non-refundable fee and will not be covered by your insurance company. In addition, any missed appointment fee must be paid before your next appointment can be scheduled. If you fail to confirm your appointment at least 24 hours in advance, your appointment may be cancelled. If we must cancel your appointment due to your lack of confirmation, we will make every possible effort to notify you of the cancellation.

"Should my account become overdue and subsequently transferred to a collection agency, I specifically agree to pay a collection fee of forty (40%) to Taylor and Carter Family Dentistry and/or its assignee and the other collection fees outlined above in recovery associated with the collection of this debt in addition to the outstanding debt."

You agree, in order for us to service your account or to collect any amounts you may owe us, we may call you at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also communicate with you by sending text messages or e-mails to your wireless number or e-mail address. Methods of contact may include using a pre-recorded/artificial voice and/or the use of an automated dialing device. These authorizations shall remain in effect until individually withdrawn by you in writing to our facility and/or others to which authorization has been extended. I have read the disclosure and agree that 'your office or agent' may contact me as described above.

I have read and understand and agree to abide by these policies.

I have read and understand the "Financial Policy and Agreement" form and know my financial responsibility as a patient and understand I am personally responsible for all charges incurred for my treatment or treatment of any others on my account. I also authorize this office to release my information for the purpose of filing insurance claims and/or necessary collections procedures. I authorize payment of my insurance directly to the dentist to be applied to my account.

_____ _____

Patient/Responsible Party Signature Date

Taylor & Carter
Family Dentistry

GENERAL CONSENT

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during and after treatment. It is equally important that you follow your dentist' s advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

I hereby authorize and direct the dentist and/or dental treatment with the use of any necessary or advisable radiographs (x-rays) and/or any other diagnostic aids in order to You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you complete a thorough diagnosis and treatment plan.

I understand x-rays, photographs, models of the mouth, and/or other diagnostic aids used for an accurate diagnosis and treatment planning are the property of the doctors, but copies of certain aids are available upon request for a fee. I hereby authorize my dentist and his/her staff to take photographs, slides, and/or videos of my face, jaws, mouth, and teeth. I understand that the photographs, slides, and/or videos will be used as a record of my care and may be used for educational purposes in study club meetings, lectures, seminars, demonstrations, and professional publications (journals, magazines). I further understand that if the photographs, slides, and/or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential.

In general terms, the dental procedures can include but not limited to:
Comprehensive oral examination, radiographs, cleaning of the teeth, and topical fluoride application. Treatment of diseased, or injured teeth with dental restorations (fillings).

Treatment of diseased or injured oral tissue secondary to traumatic injuries and/or accidents and/or infections.

I understand that the doctor is not responsible for previous dental treatment performed in other offices. I understand that, in the course of treatment, this previously existing dentistry may need adjustment and/or replacement. I realize that guarantees of results or absolute satisfaction are not always possible in dental health service.

I have answered all the questions about me or my dependent’s medical history and present health conditions, including allergies. I also understand if my dependent or I ever have any changes in health status or any changes in medication(s). I will inform the doctor at the next appointment.
I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction).
I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination.
I certify that if I, and/or my dependents have insurance coverage I assign directly to the dentist all insurance benefits for services rendered. I understand that I am financially responsible for all charges whether paid by insurance. I authorize the use of my signature on all insurance submissions.

I understand that dentistry is not an exact science, and therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized.

In addition, my dentist or their staff has given me a more detailed explanation of these treatments and procedures − if I so desired. I am fully satisfied with the description and information given, and all my questions and concerns have been satisfactorily answered.
I acknowledge that no guarantee or warranty has been made to me about the results of any of the above choices.
Therefore, I freely give my informed consent to the above treatments and procedures, should they be recommended. I further understand that this consent shall remain in effect until terminated by me.

Patient's Signature: _____ Date:_____



Patient Consent for the Disclosure of Information and Acknowledgement Form (HIPAA)

I understand that by signing this form I acknowledge consent to the following:

1. The Notice of Privacy Practices Containing a complete description of the uses and disclosures of my health information has been made available to me and I have had an opportunity to read and review all contents of said document.
2. Sharing information for the purpose of treatment: You will share my information with all members of my treatment team, both within this office and with other providers (personal and Institutional) in order to provide me or my child with quality care and educational/wellness programs specified by my insurance plan. This will include communication with our team in verbal and non-verbal form such as postcard reminders, recognition boards, sign in information, and forms of communication for patient care and office visits.
3. Sharing information for purposes of payment:
   You will share all necessary information with mine or my child's insurer(s), governmental entities, and their representatives (including, but not limited to benefit determination and utilization review) as well as your representatives involved in the billing process companies, and in extreme situations, credit bureaus or collection agencies.
4. Sharing of information for the purposes of operations:
   You will share all information necessary for ongoing operations of this office, including (but not limited to) the credentialing processes, peer review, accreditation, and compliance with all federal and state laws.

I also understand that by signing this form, I give this office permission to leave messages on my answering machine or voicemail or with a relative regarding notification of appointments, messages to call the office, test results, and any other information pertaining to mine or my child's healthcare.

Information may be left with:

Name: _____

Phone Number: _____

Relationship to Patient: _____

I understand that you will be unable to release ANY information to anyone other than the person/persons listed above. I authorize the Temporary Guardian, in the event that I cannot be contacted or if any urgency dictates, to act in loco parentis for the Child in respect of any circumstances, including any accident or illness, which may necessitate medical treatment, including surgery, and on my behalf to authorize any such treatment or surgery which they, in their sole discretion, (which discretion shall not be unreasonably exercised), may deem necessary. Medical treatment for the Child may also include dental surgery, x-ray, blood transfusion, anesthetic and medication provided any such medical treatment is performed by a duly licensed practitioner. I hereby accept full liability for all costs incurred through such medical treatment for the Child.

My consent is freely given.

Patient's Name: _____ Date: _____

Taylor & Carter
Family Dentistry

Understanding Your Insurance

Your insurance company will not cover all dental costs. It is very different than your medical insurance plan. You are responsible for your copayment/deductible and estimated patient portion of each procedure a teach visit. We will file your insurance as a courtesy to you as our patient. Any remainder not paid by insurance is due within 30 days of your statement.

Our staff does their very best to help you get the most from your insurance benefits and to answer as many questions about your plan as possible. We will **estimate** what you will owe if you have insurance, however, each company, plan and fee schedule is very different. **There will likely be additional fees that you are responsible for paying once your insurance company has completed processing your claim.** This will be billed to you by mail once your insurance company has paid us and the amount of remainder that you owe is known. Your insurance company makes the final decision on all payments allowed. If you are part of a Preferred Provider Network, we are unable to alter or discount your fees. Your fees are set directly by your insurance company. We are in network providers for Delta Dental and Arkansas Blue Cross Blue Shield. We will file your claim with other insurance companies as well but will be considered an out-of-network provider.

Your insurance policy is a contract between you and your insurance company. Any problems or discrepancies with the insurance company's payment should be directed to them as we cannot answer any questions regarding their payment decisions.

Your insurance plan does not correspond to you as an individual. Please be aware that we cannot choose your treatment based on what your insurance policy will or will not cover. You will be given the appropriate recommendations as to the **BEST** treatments for you. That means sometimes your insurance company will reject paying for certain treatments. It is your choice to accept or reject the recommended treatment. If you have concerns about the amount you will owe, please discuss those with our staff before you schedule your treatment. We WILL ONLY offer a treatment that is based on your best interest, not based on what your insurance allows or based on your plan limitations or remaining benefits. You are responsible for knowing your remaining benefits and choosing your treatment amounts accordingly. If your annual maximum benefits are exceeded, it is your responsibility to pay 100% of any overage. It is up to you to understand what your plan covers and know that you are always responsible for the full amount regardless of their payment.

You may have a waiting period for certain treatments set by your insurance company. It is your responsibility to know and understand your policy. Each policy is different, and it

is impossible for us to know the specifics of each plan. We do not use amalgam fillings in this office except in rare cases. Tooth-colored fillings are used in almost all cases. Your insurance policy will not cover these fillings at the same percentage and will therefore leave you with more out of pocket cost. We do our best to help estimate your cost, but all differences after your insurance pays will be billed to you.

Due to changes and discrepancies in secondary insurance, we can no longer estimate your portion based on anything but your primary coverage. We will be happy to file your secondary coverage for you and apply any payment to your account as a credit. However, your estimated portion based on your primary insurance will be due at the time of each service.

Your insurance coverage is basically a “coupon” toward dental services. It is not intended to cover your costs as a patient. Dental insurance began to be established in the 1970’s with most plans offering a $1,000 maximum benefit. More than 30 years later, your benefit is likely almost the same. Although your premiums continue to increase, your coverage maximum rarely does. This means as dental costs rise, your insurance company does not increase your coverage, only what you pay to them. Once your maximum is used, all fees incurred in this office will be 100% “out-of-pocket”. Additional treatments to keep your mouth in good health will still be recommended by our office without regard to your insurance coverage so that we may educate you on your needs and treat accordingly. It is in your best interest to continue treatments in order to maintain optimal health. Don’t let your insurance company decide what’s best for you.

Patient Signature:_____ Date:_____