

**Patient Information**  
**Carol G. McKown, M.S., D.D.S., P.C.**  
**(317) 846-3496**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_  
 Male  Female Date of Birth \_\_\_\_\_  
Child lives with  Both Parents Listed Below  Mother  Father

Whom may we thank for referring you to us? \_\_\_\_\_

**Responsible Party Information:**

Name \_\_\_\_\_  
Last First MI  
Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_  
Address \_\_\_\_\_ Zip \_\_\_\_\_  
Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_  
E-mail address \_\_\_\_\_  
Marital Status \_\_\_M \_\_\_S \_\_\_D \_\_\_W

**Other Parent's Name** \_\_\_\_\_  
Last First MI  
Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_  
Address Same As Above   
Address \_\_\_\_\_  
Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_  
E-mail address \_\_\_\_\_  
Marital Status \_\_\_M \_\_\_S \_\_\_D \_\_\_W

**Insurance Information: Insured's Relationship to patient:** \_\_\_\_\_

<b><u>Primary</u></b>	Insured's ID# _____
Name of Insured _____	Insured's DOB _____
Insured's SS# _____ Employer _____	Occupation _____
Insurance Company _____	Group Number _____
Insurance Co. Address _____	Phone # _____

**Appointment Confirmation:**

Which method would you prefer for having your appointment confirmed? You may select as many options as you'd like.

1 day before appointment  2 days before appointment

E-Mail: \_\_\_\_\_  
Text to Cellular Device: \_\_\_\_\_  
Land Line Phone Call \_\_\_\_\_

I will be responsible for all fees incurred in the treatment of my child. *Please be aware that the parent bringing the child in for care is the one legally responsible for the payment of all fees.* Insurance is submitted as a courtesy and payment is due in full within 60 days of appointment. I will be responsible for any collection fees incurred if a third party collection company must be retained.

Signature \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_



Carol G. McKown, M.S., D.D.S., P.C.

Pediatric Dentistry

12188 A North Meridian Street, Suite 365

Carmel, IN 46032

(317) 846-3496

### CHILD DENTAL MEDICAL HISTORY

Patient's Name \_\_\_\_\_  
Last First I Date of Birth

Parent's Name \_\_\_\_\_

### CIRCLE THE APPROPRIATE ANSWER

#### DENTAL HISTORY

1. Is this the child's first visit to a dentist? \_\_\_\_\_ YES NO  
If not, how long since the last visit to the dentist? \_\_\_\_\_
2. When was the last time the teeth were cleaned? \_\_\_\_\_
3. Does child eat between meals? \_\_\_\_\_ YES NO
4. Does child eat sweets (candy, soda, gum)? \_\_\_\_\_ YES NO
5. Does child eat well balanced meals? \_\_\_\_\_ YES NO
6. Does child brush teeth upon rising? \_\_\_\_\_ YES NO  
When going to bed? \_\_\_\_\_ YES NO  
After eating any food? \_\_\_\_\_ YES NO
7. Do you live in an area with fluoridated water? \_\_\_\_\_ YES NO
8. Have teeth been treated with fluoride? \_\_\_\_\_ YES NO
9. Does your child have any oral habits? \_\_\_\_\_ YES NO
10. Have cavities been noted in the past? \_\_\_\_\_ YES NO
11. Were any teeth removed by extraction? \_\_\_\_\_ YES NO
12. Was it suggested that space be maintained? \_\_\_\_\_ YES NO
13. Was an appliance placed? \_\_\_\_\_ YES NO
14. Have there been any injuries to teeth (chips, blows, falls)? If so, describe  
\_\_\_\_\_ YES NO
15. Has child had any unfavorable dental experience? \_\_\_\_\_ YES NO
16. How many children in your family? \_\_\_\_\_
17. Has anyone in family had orthodontics? \_\_\_\_\_ YES NO
18. Has child ever had occlusal sealants? \_\_\_\_\_ YES NO

**MEDICAL HISTORY**

- 1. Is child in good health? \_\_\_\_\_ YES NO
- 2. Is child under the care of a physician? If yes, since when? \_\_\_\_\_ Why? \_\_\_\_\_ YES NO
- 3. Name of Physician \_\_\_\_\_
- 4. Is child receiving medication? When? \_\_\_\_\_ Why? \_\_\_\_\_ YES NO
- 5. Has child had any serious illness? When? \_\_\_\_\_ Why? \_\_\_\_\_ YES NO
- 6. Is child allergic to penicillin, antibiotics or other drugs? \_\_\_\_\_ YES NO
- 7. Does child have any other allergies? \_\_\_\_\_ YES NO
- 8. Has child had surgery? \_\_\_\_\_ YES NO
- 9. Is surgery contemplated? \_\_\_\_\_ YES NO
- 10. Is child subject to profuse bleeding? \_\_\_\_\_ YES NO
- 11. Is child subject to nervous disorders? \_\_\_\_\_ YES NO
- 12. Is child subject to fainting or dizziness? \_\_\_\_\_ YES NO

**Has child had any of the following:**

- |                                |                              |                                |
|--------------------------------|------------------------------|--------------------------------|
| ___ Anemia                     | ___ Chromosome Abnormalities | ___ Jaundice                   |
| ___ Arthritis                  | ___ Diabetes                 | ___ Kidney Problems or Disease |
| ___ Artificial Joint           | ___ Epilepsy/Seizures        | ___ Psychiatric Disorders      |
| ___ Asthma                     | ___ Glaucoma                 | ___ Radiation Treatment        |
| ___ Autistic Spectrum Disorder | ___ Heart Disease/Attack     | ___ Rheumatic Fever            |
| ___ Cancer                     | ___ Heart Murmur             | ___ Scarlet Fever              |
| ___ Cerebral Palsy             | ___ Heart Surgery            | ___ Stroke                     |
| ___ Cold Sores                 | ___ Hepatitis A, B, C        | ___ Thyroid Disease            |
| ___ Congenital Heart Defect    | ___ HIV/AIDS                 | ___ Tuberculosis               |
| ___ Congestive Heart Failure   | ___ Hypertension             | ___ Ulcer                      |

Please list: \_\_\_\_\_

Other conditions/diseases not listed: \_\_\_\_\_

Source of Referral: \_\_\_\_\_

**I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.**

Parent's/Guardian's

Signature \_\_\_\_\_ Date \_\_\_\_\_

Dentist's Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient's Name \_\_\_\_\_

Office Use	CC _____
	Re-care _____

Our Office Policy Regarding Dental Insurance

We accept all types of dental insurance, however; we are in **No** networks. 2 options are offered to our patients with dental insurance. In either case you must provide us with current insurance information.

- Option 1: You may pay in full at time of service. We will then submit your insurance to reimburse you directly.
- Option 2: You may leave a HSA or credit card number on file with us. We will then submit your insurance to pay us directly. Your signature below allows us to run your credit card for any balance on your account, and mail a statement and your credit card receipt to you.

**Please circle your option of choice.** Thank you for your cooperation.

\*\*For patients covered by **Delta Dental** of Michigan, Ohio, and Indiana, Delta Dental will reimburse you directly, so please circle option 1.

Your Name: \_\_\_\_\_

Date: \_\_\_\_\_

Dr. Carol G. McKown, M.S., D.D.S., P.C.

# NOTICE OF PRIVACY PRACTICES

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**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.  
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

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## **OUR LEGAL DUTY**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect February 8, 2011, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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## **USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

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## **PATIENT RIGHTS**

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$.25 for each page, \$10.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before February 8, 2011. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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## **QUESTIONS AND COMPLAINTS**

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer:	Dr. Carol G. McKown, D.D.S. 12188-A N. Meridian, Suite 365 Carmel, Indiana 46032 (317) 846-3496	U.S. Department of Health & Human Services Office of Civil Rights 200 Independence Avenue, S.W. Washington, D.C. 20201 1-877-696-6775
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This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (February 8, 2010).

# Notice of Privacy Practices Acknowledgment

Carol G. McKown, MS, DDS, PC  
12188-A N. Meridian St., #365  
Carmel, IN 46032

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received the *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change the *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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### Office Use Only

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

**Date:** \_\_\_\_\_ **Initials** \_\_\_\_\_ **Reason** \_\_\_\_\_

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