

# CAPITAL AREA PEDIATRICS

3937 Patient Care Dr. Ste. 101  
Lansing MI 48911  
517.394.6484 Fax: 517.394.7785

## PATIENT INFORMATION

Patient's Legal Name: \_\_\_\_\_ DOB: \_\_\_\_\_ ( ) Male ( ) Female

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Patient Resides with Mother and Father ( ) Yes ( ) No **If no, please list:** \_\_\_\_\_

### Parent/Guardian's information (please circle): ( ) Male ( ) Female

Legal Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_ Ext: \_\_\_\_\_

**Which phone number is the best number to reach you? ( ) Home ( ) Cell ( ) Work** OK to leave a message? ( ) Yes ( ) No

Insurance Company Name: \_\_\_\_\_ ( ) Primary ( ) Secondary

### Parent/Guardian's Information (please circle): ( ) Male ( ) Female

Legal Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_ Ext: \_\_\_\_\_

Insurance Company Name : \_\_\_\_\_ ( ) Primary ( ) Secondary

### Information on Parent Child Does Not Live With (if applicable): ( ) Male ( ) Female

Legal Name: \_\_\_\_\_ DOB: \_\_\_\_\_ ( ) Male ( ) Female

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_ Ext: \_\_\_\_\_

**Which phone number is the best number to reach you? ( ) Home ( ) Cell ( ) Work** OK to leave a message? ( ) Yes ( ) No

Insurance Company Name : \_\_\_\_\_ ( ) Primary ( ) Secondary

Relationship to Child: ( ) Father ( ) Mother ( ) Guardian ( ) Other: \_\_\_\_\_

### Medicaid Insurance Information:

Does the child have Medicaid Insurance? ( ) Yes ( ) No **If yes, Medicaid ID #:** \_\_\_\_\_

**Emergency Contact** (other than parents): Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

### I certify the above information is true and correct to the best of my knowledge:

Guarantor's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guarantors relationship to the Child: ( ) Father ( ) Mother ( ) Guardian ( ) Other : \_\_\_\_\_

**CAPITAL AREA PEDIATRICS**

**HEALTH HISTORY (2 MONTHS -4 YEARS)**

<b>NAME</b>	<b>DATE OF BIRTH</b>		
<b>PREGNANCY AND BIRTH HISTORY</b>			
What was this child's birth weight? _____ Length at birth _____			
Did mother have any problems during the pregnancy? <input type="checkbox"/> No Problems <input type="checkbox"/> Illness requiring medication <input type="checkbox"/> Bleeding problem <input type="checkbox"/> High blood pressure <input type="checkbox"/> Sugar Diabetes <input type="checkbox"/> Premature Labor <input type="checkbox"/> Other _____			
Was birth of child within 2 weeks of due date? <input type="checkbox"/> Yes <input type="checkbox"/> No			
What type of delivery did the child have? <input type="checkbox"/> Vaginal delivery <input type="checkbox"/> C/Section delivery Reason _____			
Did child have problems in the newborn nursery <input type="checkbox"/> No problems <input type="checkbox"/> Yellow jaundice <input type="checkbox"/> Low blood sugar <input type="checkbox"/> Infection <input type="checkbox"/> Other _____			
Did child go home with mom from the hospital <input type="checkbox"/> yes <input type="checkbox"/> No			
<b>PAST MEDICAL HISTORY</b>			
Has your child ever been hospitalized overnight? <input type="checkbox"/> No <input type="checkbox"/> Yes Reason _____			
Has your child had any surgery? <input type="checkbox"/> No <input type="checkbox"/> Yes Types of Surgery _____			
Has your child had any serious injury requiring medical attention <input type="checkbox"/> No <input type="checkbox"/> Yes Explain _____			
Has your child ever been diagnosed as having any of these problems? <input type="checkbox"/> Allergies <input type="checkbox"/> Asthma <input type="checkbox"/> Bladder/kidney infection <input type="checkbox"/> Chicken pox <input type="checkbox"/> Recurrent ear infection <input type="checkbox"/> Eczema <input type="checkbox"/> Hay fever <input type="checkbox"/> Heart problems <input type="checkbox"/> Pneumonia <input type="checkbox"/> Seizure <input type="checkbox"/> Recurrent sinusitis <input type="checkbox"/> Recurrent sore throat <input type="checkbox"/> Wheezing <input type="checkbox"/> Other medical problems _____			
<b>ALLERGIES/MEDICATIONS/IMMUNIZATION</b>			
Does your child have any allergy to medications? <input type="checkbox"/> No <input type="checkbox"/> Yes Explain _____			
Is your child currently on any medications <input type="checkbox"/> No <input type="checkbox"/> Yes List all prescription medications that your child is on: _____			
Does your child receive a fluoride supplement? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Are your child's immunizations up to date? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know (Please provide us with a copy of your child's immunizations)			
<b>TUBERCULOSIS RISK ASSESSMENT</b>		<b>NO</b>	<b>YES</b>
Has your child ever had a positive TB skin test?			
Has any member of this child's family or anyone hat this child spends time with had a positive TB skin test or been treated for tuberculosis?			
<b>EDUCATIONAL HISTORY</b>			
Has your child received services from Early On? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is reason your child was referred? _____			
Does your child attend a Headstart program or preschool? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, do you or the teacher have any concern about how he is doing in this program <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Please list any other information about your child that you would like us to know or any concerns you have at this time</b>			
_____			
_____			
_____			
_____			
Parent or Guardian's signature			Date
Reviewed by provider			Date

# Capital Area Pediatrics

# Social History Form

Patient Name	Date of Birth
Mother's Name	Mother's Occupation

Mother's Education (Check any that apply)  
 GED  High School Diploma  College graduate  Some college/training  Graduate School  Post Graduate

Father's Name	Father's Occupation
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Father's Education (Check any that apply)  
 GED  High School Diploma  College graduate  Some college/training  Graduate School  Post Graduate

Parent's Current Relationship  
 Married  Separated  Divorced  Living Together  A couple but not Living together  No longer together as a couple

If parents are not living in the same household, what is the custody arrangement?  
 Lives with mom  Lives with Dad  Joint Custody  Shared custody- weekends  Shared custody- summers

Is the other parent involved?  
 Father has regular visitation  Mother has regular visitation  Father not involved  Mother not involved

**List all people living in child's household**

Name	DOB (MM/YY)	Relationship to child	Name	DOB (MM/YY)	Relationship to child

What is the current child care arrangement?  
 Mother doesn't work outside the home  Father doesn't work outside the home  Parents work different hours  
 Cared for by a relative  Day Care Home  Day care center  Babysitter/ Nanny  Other: \_\_\_\_\_

Have there been any recent stresses in the family?  
 Parental job loss  Parental job change  Family move  Major illness in family member  Death in family  
 Recent parental separation/divorce  Loss of insurance  Homeless/ Living in a shelter/ friend's house  Other: \_\_\_\_\_

What is the child's race? Check those that apply  
 American Indian or Alaska Native  Asian  Black or African American  
 Native Hawaiian or Pacific Islander  White  I don't wish to identify my child's race

What ethnicity is your child?  
 Hispanic or Latino  Not Hispanic or Latino  I do not wish to identify my child's ethnicity

What is the Primary Language spoken in your home?  
 English  Hindi  Spanish  Other \_\_\_\_\_

What is the source of drinking water at the home where the child lives?  
 Well water  Bottled water  Bottled water w/ fluoride  Lansing city  Other city: \_\_\_\_\_

Does anyone who lives in your house smoke?  
 No one smokes at home  Mother smokes in home  Father smokes in home  Family members smoke in home  
 Mother smokes outdoors only  Father smokes outdoors only  Family members smoke outdoors only

For children 6 yrs or less to help us assess your child's risk of lead exposure, please check all that apply:  
 Live in a house Built before 1950  Live in a house built between 1950 and 1978  Visits a house built before 1950 regularly  Child has a playmate/ sibling that has been diagnosed w/ lead poisoning

Do you live in a house that has undergone major remodeling recently?  Yes  No

Parent/Guardian Signature: \_\_\_\_\_

**Capital Area Pediatrics****Family History Form**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Does any biologic relative (Parents, Grandparents, Siblings, Aunt/Uncle) have any of the following health problems?

**Please circle yes or no for each of the following health problems:****Name the family members that have the problem by listing their relation to the child****Respiratory or Allergies**

Asthma Yes No

Allergies Yes No

Allergic Rhinitis Yes No

Eczema Yes No

Other: \_\_\_\_\_

**Cardiovascular Diseases**

Heart disease in male family member before age 55 Yes No

Heart disease in female family member before age 65 Yes No

Sudden Unexpected Death Yes No

Heart Attack Yes No

Angina Yes No

Coronary Artery Disease Yes No

Stroke Yes No

Blood clots Yes No

High Blood Pressure Yes No

Arrhythmia Yes No

Other: \_\_\_\_\_

**Mental Health Concerns**

Depression Yes No

Attention Deficit Hyperactivity Disorder Yes No

Anxiety Disorder Yes No

Alcohol/Drug Abuse Yes No

Other: \_\_\_\_\_

**Inherited Disease**

Sickle Cell Trait Yes No

Sickle Cell Anemia Yes No

Hearing Loss Yes No

Birth Defect Yes No

Other Inherited Disease: \_\_\_\_\_

**Miscellaneous**

Cancer Yes No

Seizure Disorder Yes No

Epilepsy Yes No

High Cholesterol Yes No

Diabetes Yes No

Problems with anesthesia Yes No

List any other health problems in your family that are not previously listed: \_\_\_\_\_

Parent/ Guardian Signature

Date

Reviewed by Provider

Date

**Capital Area Pediatrics**  
3937 Patient Care Drive, Suite 101  
Lansing, Michigan 48911  
(517) 394-6484 fax (517) 394-7785

**Authorization for Disclosure of Protected Health Information**

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

Birth Date \_\_\_\_\_

Address \_\_\_\_\_

Phone No. \_\_\_\_\_

1. I authorize disclosure of the protected health information (child's name) \_\_\_\_\_ be made by:

**Previous Practice Name:** \_\_\_\_\_

**Address** \_\_\_\_\_

**Phone** \_\_\_\_\_ **Fax** \_\_\_\_\_

Information to be disclosed will include, as applicable, unless crossed out:

- Alcohol and drug abuse and mental health treatment information protected under the regulations in Title 42 of Code of Federal Regulations Part II.
- Information about human immunodeficiency virus-HIV acquired immunodeficiency syndrome-AIDS, and AIDS related complex-ARC, as defined by Department of Community Health rules (1989 Public Act 174)

2. Person or organization authorized to receive information:

**Capital Area Pediatrics**  
**3937 Patient Care Drive, Suite 101**  
**Lansing, MI 48911**

3. Specific Type of information to be disclosed.

Entire Record       Immunization Records       Records from visit on \_\_\_\_\_

Other \_\_\_\_\_

4. This information may be disclosed for the following purpose:

Continued Care       Personal Use       Attorney Use       Insurance Use

Other \_\_\_\_\_

5. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment.

6. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by state or federal privacy laws and regulations, the information described above may be disclosed and no longer protected by those laws and regulations

7. I understand that I may revoke this authorization at any time by notifying Capital Area Pediatrics in writing by sending a letter to the attention of the office manager. However, the revocation will not be valid if Capital Area Pediatrics has taken action in reliance on this authorization.

8. This authorization expires 365 days from date of the signature below unless otherwise requested.

\_\_\_\_\_  
Printed name of patient or patient's representative

\_\_\_\_\_  
Relationship to child

\_\_\_\_\_  
Signature of patient or patient's representative

\_\_\_\_\_  
Date

Capital Area Pediatrics has verified the identification of patient's representative

Person known to staff       driver's license/state identification       other \_\_\_\_\_

# Capital Area Pediatrics

## Written Acknowledgment of Patient Centered Medical Home Contract Receipt of Notice of Privacy Practices Receipt of Appointment Cancellation Policy

I have received a copy of Capital Area Pediatrics Medical Home Contract, Notice of Privacy Practices and Cancellation Policy.

I understand that if my child misses three appointments in a 12 month period, he/she and all other children in the household will no longer be able to receive medical care from Capital Area Pediatrics.

I, \_\_\_\_\_, acknowledge receipt of these policies on behalf of  
Parent or Guardian





my child \_\_\_\_\_ whose date of birth is \_\_\_\_\_.  
Patients name

Signature \_\_\_\_\_  
Parent or Guardian

Date \_\_\_\_\_

Relationship to child \_\_\_\_\_

**Capital Area Pediatrics, P.C.**  
**Financial Policy**  
**April 2018**

- It is important for you to know your insurance coverage such as co-pays, deductibles, co-insurances, policy limitations and services that are not a covered benefit. Listed below are some additional out-of-pocket expenses you may encounter:
  - Care Management
  - Evening Appointments
  - Office Procedures (Umbilical Cauterization, Wart Removal, Etc.)
  - Out-of-Network Services
  - Phone Encounters
  - Travel Consults
  - Well Child Visits Combined With Medical Conditions
- You are responsible for keeping our office informed of any changes to your addresses, phone numbers, or insurances.
- In order to keep your accounts up-to-date please present your ID and/or insurance cards when asked.
- **Important!** Our office does not bill based on court documents. The parent who accompanies a child for a visit will be responsible for any charges.
- We accept    , cash, checks, and money orders. Payments can also be made by phone or through our Patient Portal.
- Medicaid – We only accept Medicaid for established patients or if it is your secondary/tertiary insurance. We only participate with straight Medicaid, Blue Cross Complete of Michigan and McLaren Medicaid. If you have any other Medicaid insurances or inactive/pending Medicaid your appointment may be cancelled or you may be considered a “Cash” patient.
- **New Patients** – We do not accept Medicaid or any Medicaid HMO as a primary insurance. If your child converts to one of these within 180 days of their first visit they will be considered for discharge.
- **Missed Appointment Policy** - If a scheduled appointment is missed, cancelled with less than a 4 hour notice or you are more than 15 minutes late it is considered a "Missed Appointment". Your family is allowed 3 Missed Appointments in a 12 month period.
- **No Show Policy** - If you “No Show” for a scheduled appointment and have not called our office a \$20.00 fee will be charged to your account.
- Returned Check Fee: \$40.00
- FMLA Form Fee: \$20.00
- Medical Records Fees:
  - Paper: \$35.00 Maximum (\$1.00 per page)
  - Compact Disc: \$25.00
  - No charge to transfer records directly to a new provider.
- Other Form Fees: Amount charged is at the provider’s discretion.
- Failure to follow any of the above conditions may result in the discharge of your family.

**Assignment of Benefits:** For all services rendered by Capital Area Pediatrics, P.C. I authorize my insurance to issue all payments directly to them. I understand that I am responsible for any amounts not covered by my insurance.

**I have read, understand and agree to this Financial Policy for all of my children seen at Capital Area Pediatrics, P.C.:**

Guarantor’s Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_ Date: \_\_/\_\_/2018

Guarantor’s Relationship to the Child: ( ) Father ( ) Mother ( ) Guardian ( ) Other: \_\_\_\_\_

*Optional:* Please provide your email address to send/receive secure messages from our Patient Portal:

Office Use Only: Portal Invite sent on __/__/2018		[ ] Existing Portal Acct
Pat Name:	Pat Name:	Pat Name:
Pat#:	Pat#:	Pat#:
Pat Name:	Pat Name:	Pat Name:
Pat#:	Pat#:	Pat#: