

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)

NAME	DATE OF BIRTH
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PREGNANCY AND BIRTH HISTORY

What was this child's birth weight? _____ Length at birth _____

Did mother have any problems during the pregnancy? No Problems Illness requiring medication Bleeding problem High blood pressure Sugar Diabetes Premature Labor Other _____

Was birth of child within 2 weeks of due date? Yes No

What type of delivery did the child have? Vaginal delivery C/Section delivery
Reason _____

Did child have problems in the newborn nursery No problems Yellow jaundice Low blood sugar Infection Other _____

Did child go home with mom from the hospital yes No

PAST MEDICAL HISTORY

Has your child ever been hospitalized overnight? No Yes
Reason _____

Has your child had any surgery? No Yes Types of Surgery _____

Has your child had any serious injury requiring medical attention No Yes Explain _____

Has your child ever been diagnosed as having any of these problems? Allergies Asthma Bladder/kidney infection Chicken pox Recurrent ear infection Eczema Hay fever Heart problems Pneumonia Seizure Recurrent sinusitis Recurrent sore throat Wheezing Other medical problems _____

ALLERGIES/MEDICATIONS/IMMUNIZATION

Does your child have any allergy to medications? No Yes Explain _____

Is your child currently on any medications No Yes List all prescription medications that your child is on: _____

Does your child receive a fluoride supplement? Yes No

Are your child's immunizations up to date? Yes No I don't know (Please provide us with a copy of your child's immunizations)

TUBERCULOSIS RISK ASSESSMENT

NO	YES
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Has your child ever had a positive TB skin test?

Has any member of this child's family or anyone that this child spends time with had a positive TB skin test or been treated for tuberculosis?

EDUCATIONAL HISTORY

Has your child received services from Early On? Yes No
If yes, what is reason your child was referred?

Does your child attend a Headstart program or preschool? Yes No

If yes, do you or the teacher have any concern about how he is doing in this program Yes No

Please list any other information about your child that you would like us to know or any concerns you have at this time

Parent or Guardian's signature

Date

Reviewed by provider

Date

Capital Area Pediatrics

Social History Form

Patient Name	Date of Birth
Parent/Guardian's Name and Relation to Child	Parent/Guardian's Occupation

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

Parent/Guardian's Name and Relation to Child	Parent/Guardian's Occupation
Parent/Guardian's Education (Check any that apply) <input type="checkbox"/> GED <input type="checkbox"/> High School Diploma <input type="checkbox"/> College graduate <input type="checkbox"/> Some college/training <input type="checkbox"/> Graduate School <input type="checkbox"/> Post Graduate	

Parent/Guardian'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

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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

- 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: __/__/ 20

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#: