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 (BIRTH-2 MONTHS)**

Name	Date of Birth

PREGNANCY AND BIRTH HISTORY

Where was your baby born? ☐ Sparrow ☐ McLaren ☐ Other

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 _____

If there were problems with the pregnancy please explain your understanding of the problems and the treatment given: _____
_____
_____
_____
_____

What was the baby's expected due date?

What type of delivery did the child have? ☐ Vaginal delivery ☐ C/Section delivery- If the baby was born by C/Section, what was the 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

Was your child in the NICU? ☐ Yes ☐ No

Please explain your understanding of the problems and the treatment given to your baby in the newborn nursery or NICU: _____
_____
_____
_____
_____

Did this Child receive a Hepatitis B vaccine in the hospital? ☐ Yes ☐ No

Is your child currently on any medications? ☐ No ☐ Yes Please list any medications that the child is on:
_____
_____

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

Parent/Guardian Signature	Date

Capital Area Pediatrics — Social History Form

Patient Name	Date of Birth

Parent/Guardian's Name	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	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'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: _____Date:_____

Capital Area Pediatrics **Family History Form**

Name Patient: _____ 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

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_____ Date_____
Parent or Guardian

Relationship to child_____

Capital Area Pediatrics, P.C.
Financial Policy

1. 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
2. You are responsible for keeping our office informed of any changes to your addresses, phone numbers, or insurances.
3. In order to keep your accounts up-to-date please present your ID and/or insurance cards when asked.
4. **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.
5. We accept  , cash, checks, and money orders. Payments can also be made by phone or through our Patient Portal.
6. 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.
7. **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.
8. **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.
9. **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.
10. Returned Check Fee: $40.00
11. FMLA Form Fee: $20.00
12. 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.
13. Other Form Fees: Amount charged is at the provider's discretion.
14. 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 __/__/__	[ ] Existing Portal Acct	
Pat Name:	Pat Name:	Pat Name:
Pat#:	Pat#:	Pat#:
Pat Name:	Pat Name:	Pat Name
Pat#	Pat#	Pat#