

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):

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):

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):

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
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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
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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 Live in a house built Visits a house built Child has a playmate/ sibling that has
 Built before 1950 between 1950 and 1978 before 1950 regularly been diagnosed w/lead poisoning

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

Parent/Guardian: _____ Date: _____

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
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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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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

Thank you for choosing Capital Area Pediatrics. We strive to provide the best quality care for our patients and families. Please carefully read the following, initial, sign and return to our office. Please contact our office if you have any questions.

1. It is your responsibility to know your benefits prior to any visit. To avoid unexpected balances, you should contact your insurance company prior to the visit to ensure that you know your benefits and limitations. In addition, while most insurance companies cover well child visits (including vaccines, screening, counseling, etc) at no cost to you, your insurance plan may charge for additional procedures done during a well child visit. Furthermore, any additional health concerns discussed or addressed during a well child visit (outside of the growth and development of your child), your insurance company may consider these two separate visits and may apply a patient responsibility (depending on your benefits: copay, deductibles, co-insurances, etc.).

Some examples of procedures that may have an out-of-pocket expense (but not limited to):

- **Evening Appointments** (appointments made at 5:00 pm or after)
- **Photo Vision Screen**
- **Hearing Screen**
- **In-House Labs**
- **Umbilical Cord Chemical Cauterization**
- **Wart Removal**
- **Ear Wax Removal**
- **Abscess Drainage**
- **Telemedicine visits** (video or phone)
- **Afterhours Phone Calls (On-Call or Other Parent-Initiated Calls)**
- **Travel Consults/Travel Vaccines**
- **Well Child Visits Combined with Other Non-Preventative Concerns** (Behavioral Questions, Asthma Questions, Non-Preventative Questions, Medication Refills, Referrals, Labs, Other Procedures, Etc.)
- **Additional Time Spent Evaluating and Addressing Non-Preventative Concerns**
- **Out-of-Network Services/Non-Covered Services**
- **Care Management**

Initials: _____

2. It is your responsibility to provide our office with your current insurance information. Currently, we are asking all parents/guardians to provide all insurance cards and photo identification to update our records. In addition, please informed our office of any changes, such as change in insurance, address, phone number, etc.
3. **Important! Our office does not bill based on court documents. The person (parent/guardian/other) who brings the child to the appointment is responsible for any charges from that visit, including copays and additional expenses.** If your insurance is inactive and you

are considered "cash patient", payment is due at the date of visit/check-out. We are happy to accept



, cash,

4. 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 Health Plan, your appointment may be cancelled, or you may have to pay out of pocket for visit.
5. **New Patients** – We do not accept Medicaid or any Medicaid HMO as a primary insurance. If your child converts to Medicaid as primary insurance within 90 days of their first visit they will be considered for discharge.
6. **Missed/No Show Appointment Policies:**
 - **Missed Appointment Policy** - If a scheduled appointment is missed, meaning 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 and considered for discharged after the 3rd missed appointment.
 - **No Show Policy** - If you "No Show" for a scheduled appointment, meaning you did not call our office to let us know that you could not make the appointment, a **\$20.00 fee** will be charged to your account.

Initials: _____

7. Medical Records Fees (only for personal copies):
 - Paper: \$35.00 Maximum (\$1.00 per page)
 - Compact Disc: \$25.00
8. Sports Physical Appointments: \$30
9. Returned Check Fee: \$40.00
10. FMLA Form Fee: \$20.00
11. 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 _____, parent of _____

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

Guarantor's Signature:

Date: _____

Guarantor's Relationship to the Child: () Father () Mother () Guardian () Other: _____



**Capital Area Pediatrics, P.C.
Portal Invite**

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

Office Use Only:

Pat#:

Pat Name:

Pat#:

Pat Name:

Pat#:

Pat Name:

Pat#:

Pat Name:

Pat#:

Pat Name:

Pat#:

Pat Name:

