

# 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: \_\_\_\_\_

Do we have your permission to contact you at... ( ) 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 the child have problems in the newborn nursery?  No problems  Yellow jaundice  Low blood sugar  Infection  Other

Did the 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
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Mother's Name	Mother's Occupation
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Mother's Education (Check any that apply)

GED  High School Diploma  College graduate  Some college/training  Graduate School  Postgraduate

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  Postgraduate

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.

Are the other parents 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 childcare 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  Another 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 biological relative (Parents, Grandparents, Siblings, Aunt/Uncle) have any of the following health problems?

<b>Please circle yes or no for each of the following health problems:</b>	<b>Name the family members that have the problem by listing their relation to the child</b>
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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, 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):**

- Photo Vision Screen
- Hearing Screen
- In-House Labs
- Umbilical Cord Chemical Cauterization
- Wart Removal
- Ear Wax Removal
- Abscess Drainage
- Telemedicine visits (video or phone)
- Online services through portal
- 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 inform 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, checks, and money orders. Payments can also be made by phone or through our Patient Portal.

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 a visit.
5. **New Patients – We do not accept Medicaid or any Medicaid HMO as 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 discharge after the 3<sup>rd</sup> 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 35 pages (\$1.00 per additional page)
  - Compact Disc: \$35.00
8. Sports Physical Appointments: \$35
9. Returned Check Fee: \$40.00
10. FMLA Form Fee: \$35.00
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:

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Office Use Only:

Pat#:	Pat#:	Pat#:
Pat Name:	Pat Name:	Pat Name:
Pat#:	Pat#:	Pat#:
Pat Name:	Pat Name:	Pat Name:

# 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 \_\_\_\_\_

