Capital Internal Medicine Associates, P.C.

*A New Beginning OB/GYN *CIMA Acute Bridging Clinic *CIMA Breast Center *CIMA Heart Institute
*CIMA Main Office *CIMA Primary Care * Haslett Primary Care *Kozmic Family Practice
*Mason Internal Medicine *Williamston Primary Care

PLEASE COMPLETE THIS PEDIATRIC QUESTIONNAIRE

Patient Name: ______________________________ Birthdate: __/__/____

Parent Name Completing Information: ______________________________

PARENT INFORMATION

Single:____ Married: ____ Divorced:____ Separated:____ Widowed:____ Life Partner:____

Did mother smoke during pregnancy? Yes No If so, how many packs per day? __________

Did mother consume alcohol during pregnancy? Yes No How many per day? _____ Week? ______

Did mother consume caffeine? Yes No If so, how much per day? ____________________________

Did mother take any medication during pregnancy? Yes No If so, what? ______________________

Does anyone smoke in the home? Yes No How many packs per day? ________________

Does anyone in the home use any recreational drugs? Yes No If so, what? _____________________
(Marijuana, Cocaine, LSD, Speed, Crack, Heroine, Steroids, Medications not prescribed to you)

BIRTH HISTORY

☐ Vaginal Birth ☐ Caesarian If caesarian, why? ____________________________

Length of Pregnancy (# of weeks) ____________ If Premature, how early? ________________

Birth Weight: _____________________ Birth Length: ____________________

☐ Home ☐ Hospital ☐ Birthing Center

Name of Facility: ____

City: _____________________ State: _________________ Zip Code: ______________________

☐ Breast Fed, How Long? ______________ ☐ Formula, Brand/Type? ______________

☐ Other: ____

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Spanish	ATENCIÓN:	si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-517-374-7600.
Arabic	ملحوظة:	إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-517-374-7600

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IMMUNIZATIONS

Were Immunization(s) given in Michigan?   Yes   No

If the child has received immunizations, but not in Michigan, please provide when they received them and in what state they were administered: ____

If there is another name the child may have used when receiving the immunizations, please provide the name(s): ____

PATIENT HEALTH INFORMATION

PLEASE CIRCLE IF YOUR CHILD HAS BEEN DIAGNOSED WITH:

ADD/ADHD	Abdominal Pain	Allergies	Anxiety
Asthma	Birth Complications	Bone Fracture	Cancer
Chronic Ear Infections	Concussion/Head Injury	Constipation	Depression
Eczema	Headaches	Hearing Problems	Joint Pain
Piercing(s)	Poor Appetite	Rapid Pulse	Scoliosis
Seizures	Shortness of Breath	Speech Development Delay	Tattoo(s)
Vision Problems	Weight Gain	Weight Loss	

Other: ____

Any surgical implant(s)? Yes   No   If yes, where? ____

Please list any surgeries: ____

RECENT TESTING ACTIVITY

Please Indicate the Most Recent Date These Test Were Performed

Lead Levels   Date last tested: _________________
Dental   Date last exam: _________________
Hearing   Date last tested: _________________
Vision   Date last exam: _________________

LIST YOUR PREVIOUS PRIMARY CARE DOCTOR and ANY SPECIALISTS THAT YOU SEE or HAVE SEEN IN THE PAST:

____
____
____

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Family History: (Please check all boxes that apply in table below)

Please tell us about medical problems in your blood relatives. This can help us take better care of you. Fill out the chart below by checking all the appropriate boxes that apply to each relative.

	AGE (years old)	DECEASED (Y/N)	DIABETES	HYPERTENSION	HEART DISEASE/CHF/MI	STROKE	ASTHMA	CANCER	UNKNOWN	ALLERGIES	MENTAL ILLNESS	DEPRESSION	OSTEOPOROSIS	COPD	HYPERLIPIDEMIA	OTHER:
MOTHER		Y/N														
FATHER		Y/N														
MOTHERS MOTHER		Y/N														
MOTHERS FATHER		Y/N														
FATHERS MOTHER		Y/N														
FATHERS FATHER		Y/N														
BROTHERS		Y/N														
SISTERS		Y/N														
CHILDREN		Y/N														

CURRENT MEDICATIONS

Please list medication that you are currently taking.

PLEASE LIST MEDICATIONS YOU ARE USING:

MEDICATION TAKING	DOSAGE	REASON FOR USING

PLEASE LIST ANY ALLERGIES AND YOUR REACTION TO THEM

ALLERGY/MEDICATION	REACTION

Thank you for taking the time to fill out this form!

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Lansing, MI 48911
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Parental Authorization for Delegated Consent to Medical Treatment

Child Information:

____
Childs Name Date of Birth

____
Home Address City State Zip Code

____
Parental Contact Contact Number

Authorized Individual: (Designated adult over the age of 18 authorized to bring minor child to appointments in my absence)

____
Name Relation to Patient Phone Number

The above named individual shall be authorized to consent to routine and/or emergency treatment for the above named child should it be required during my absence.

[ ] I give my permission for the individual (an adult over the age of 18) listed above to bring minor child to an appointment(s), if I am unable to be present at the time of the appointment.

[ ] This consent will be in effect until ______ day _____ 20_____. Unless earlier revoked by me.

[ ] This consent for caregiver treatment has no expiration and will be revoked upon written notice only.

[ ] In the event my child is 16 years of age or older to come to an appointment unaccompanied. Established care plans may continue. Any new treatment plan must be approved by me and summary of care must be given to my child at the visit.

This consent serves as permission for treatment by Capital Internal Medicine Associates, P.C. and all its affiliate offices. I acknowledge that parental consent is not required in emergency situations. I agree to accept financial responsibility for all services provided to my child in my absence.

____
Parent/Legal Guardian (Circle one) Date

____
Witness Date

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Patient Preferences for Verbal Communication of Protected Health Information

Please help us to accommodate your wishes regarding how we communicate your health care by completing and signing this form. The following individuals are given permission to receive verbal information as indicated:
Please note the below named individuals may not access, request, or receive copies of your medical records without an Authorization for Release of Medical Records signed by you.

NAME/RELATIONSHIP	PHONE NUMBER	TYPE OF INFORMATION

☐ Yes	☐ No	May we leave a message on your voicemail regarding test results or medical advice?
☐ Yes	☐ No	May we leave information regarding an upcoming appointment or a request for you to call the office with another individual in your household? If yes, please indicate the individuals with who we may leave such a message. ☐ Spouse ☐ Other:______________________________
☐ Yes	☐ No	May we send written correspondence in a sealed envelope to your home address? In not, please indicate an alternate address where we may send confidential communications: ______________________________

Policies and Limitations on Alternate Means of Communication:

- We are required to accommodate "reasonable" requests for communicating with you by alternate means. We may deny the request if we determine that it is unreasonable.
- You agree that the security and confidentiality of the confidential information sent via alternate method is your responsibility alone, and neither the physician or the practice is responsible for any inadvertent disclosures that may occur as a result of fulfilling the request.

Print Patient Name: ______________________________

Patient Signature: ______________________________ Patient DOB: ______________________

For Office Use Only

Patient ID: __________________ Provider: ________________________ Date: __________________

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Authorization to Access External Health Information Databases

I authorize Capital Internal Medicine Associates, PC, to access any and/or all external databases available to health care providers in the State of Michigan, including Health Information Exchanges (HIE's) and/or interoperability systems which may contain my protected health information, on a frequency to be determined by my provider. I understand and acknowledge that these external databases will include, but not limited to, information reflecting prescription medications filled/ordered/or used by me, which will be used to verify current medications, coordinate care, and prevent drug interactions. This information will become part of my permanent medical record at Capital Internal Medicine Associates, P.C.

Name of Preferred Pharmacy: ____

Location of Pharmacy: ____

Patient Name (Printed): ____

I Consent Patient Signature: ____

I Refuse Patient Signature: ____

If Minor Patient, Parent/Guardian Signature: ______________________________

Patient's Date of Birth: ___________________________

Today's Date: _________________

Patient Account Number (Office use only): ___________________

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Authorization for Use or Disclosure of Information

*Patient Name: ______________________________ *Maiden/Other Name ______________________________

*D.O.B._____/_____/_______ *Phone Number (______) ____________________

*Patient Address: ____
Street City State Zip

I authorize____
Healthcare Facility/Physician

To release any and all information contained in the record which may include information regarding: **Drug and/or alcohol treatment, psychological records, HIV/AIDS and other Sexually Transmitted Disease.**

Name to whom information may be released: ____
Physician/Facility/Self

***Please send most recent:**

☐ Entire Medical Record ☐ Discharge Summary ☐ Colonoscopy ☐ Operative Reports

☐ Radiology/Diagnostic Reports ☐ Laboratory Reports ☐ Pathology Reports ☐ Progress Notes

☐ Radiology/Diagnostic Imaging ☐ Medications ☐ Immunizations ☐ Billing Records

☐ Emergency Room Records ☐ Other (Specify): ____________________________________

***Information to Be Released (From Date: ___________________ To Date: ___________________)**

Here at CIMA we are constantly trying to improve our quality of care, if you are leaving the practice please give a brief description as to why: (optional) ____

____

This authorization expires (Date): ________________ (if no date is given this release will expire one year from date of patient's signature)

I understand that, as set forth in the practice's Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification.

I understand that a revocation is not effective to the extent that the practice has relied on the use or disclosure of the protected health information.

____________________________________ ______/______/________
Signature of Patient or Personal Representative Date

____
Printed Name of Patient or Personal Representative (if necessary)

____
Person Authorized to Pick-up on Patient's Behalf

This form for Authorization for Use or Disclosure of Information is designed to comply with Title 42 of Federal Regulations, Part 2 (HIPAA).

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