Please complete this form to the best of your ability and submit to our office by mail, email, fax, or in-person.
If your child has an IEP or 504 plan in place, please submit a copy with this form.
If your child's primary care provider gave you a referral, please submit a copy with this form.

CapitalCare Developmental Pediatrics
6 Wellness Way, Suite 101
Latham, NY 12110
Phone: 518-782-7733
Fax: 518-782-0800
dpcrinfo@communitycare.com

Kindly Note:

- If you are not the child's parent, we will need documentation of guardianship/custody – you may submit that with this form.
- If you are a child's foster parent, please be sure the child's caseworker or care manager is aware you're making an appointment, and list that person's information below:
  Caseworker's Name: _____
  County or Agency: _____
  Caseworker's Phone: _____
- Your child's insurance company may require a referral or prior authorization in order to cover this appointment. Please contact your insurer to verify covered services.

Child's Name: _____
DOB: _____

Home Address:

_____

_____

_____

Parent/Guardian 1 Name(s): _____
Parent/Guardian 1 Date of Birth: _____
Guardian 1 Relationship to Child (if not parent): _____
Phone: _____
Email: _____

Home Address (if different from child):

_____

_____

_____

Mailing Address (if different from home address):

_____

_____

_____

If applicable:
Parent/Guardian 2 Name(s): _____
Parent/Guardian 2 Date of Birth: _____
Guardian 2 Relationship to Child (if not parent): _____
Phone: _____
Email: _____

Home Address (if different from child):

_____

_____

_____

Mailing Address (if different from home address):

_____

_____

_____

Insurance Company: _____

Subscriber/Policy Holder: _____
Subscriber's Date of Birth: _____
Child's Name Exactly as it Appears on Insurance Card: _____
Insurance ID: _____
Insurance Group Number: _____

Please be aware that a referral or prior authorization may be required for some insurance plans. Please contact your insurer to verify covered services.

Please list your current concerns about your child's development, and/or the reason you were referred to our practice for evaluation:

_____

_____

_____

Was your child born prematurely? If so:

What was the original due date? _____

What was their birth weight? _____

Did your child spend time in the NICU at birth?

If so, what hospital? _____

Who referred you to our practice? _____

Primary Care Pediatrician (first and last name): _____

PCP Address:

_____

_____

_____

Have any other members of your family been to our practice before? _____

If so, please provide patient's name and date of birth: _____

Has your child seen any medical specialists? Please list:

_____

_____

_____

Has your child seen a mental health provider or child psychologist? Please list:

_____

Has your child had a hearing test done? _____

If so, who administered the test? _____

When was the most recent hearing test? _____

If not, do you have any concerns about your child's ability to hear? _____

Does your child take any prescription or over-the-counter medications or supplements? Please list:

_____

_____

_____

Has your child (under age 3) been evaluated by/enrolled in your county's Early Intervention program?

_____

Has your child (age 3 and up) been evaluated by your school district (CPSE/CSE)?

_____

Has your child been evaluated by another developmental pediatrician or practice? Please list:

_____

Does your child currently receive any services like speech therapy, occupational therapy, physical therapy, special instruction, or social skills coaching? Please list:

_____
_____
_____

Does your child attend school or pre-school? Please list: _____
Does your child have an IEP or 504 plan in place? _____
If so, please submit a copy of their plan with this form.

What happens now?

Once we receive your form, we will review your child's information and reach out by phone to schedule within 7-10 business days. If you do not hear from our office within that time frame, please feel free to call or text us and let us know you submitted an intake form.