



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

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:

- The patient's custodial parent or legal guardian should plan to attend the first appointment. If anyone other than the parent/guardian is planning to bring the child, please contact our office ahead of time to discuss.
- If you will need help arranging transportation to your appointment, please let us know when you schedule.
- 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:		Date of Birth:	
Home Address:		Gender:	
City:		State:	Zip:
Primary Language:			

Who referred you to our practice?

Primary Care Pediatrician (first and last name):

PCP Address:

City, State, Zip:

Parent/Guardian 1 Name:

DOB: Relationship to Child:

Phone: Email:

Home Address (if different from child) Mailing Address (if different from home)

Street:	<input type="text"/>	Street:	<input type="text"/>
City:	<input type="text"/>	City:	<input type="text"/>
State:	<input type="text"/>	State:	<input type="text"/>

If Applicable

Parent/Guardian 2 Name:

DOB: Relationship to Child:

Phone: Email:

Home Address (if different from child) Mailing Address (if different from home)

Street:	<input type="text"/>	Street:	<input type="text"/>
City:	<input type="text"/>	City:	<input type="text"/>
State:	<input type="text"/>	State:	<input type="text"/>

Child's Medical Insurance Provider

Subscriber/Policy Holder's Name:

Subscriber's Date of Birth:

Child's Name EXACTLY as appears on Card:

Insurance ID Number:

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 yes:

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?

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

If so, please provide patients' names and dates of birth:

Has your child seen any medical specialists? Please list below:

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

Has your child had a hearing test?

Do you have any hearing concerns?

Who administered the test?

When was the most recent test?

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

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

Has your child (age 3+) been evaluated by your school district? (CPE/CPSE)

Has your child been evaluated by another developmental pediatrician or practice? If so, whom:

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? If so, where?

Does your child have an IEP or 504 plan in place?

If so, please submit a copy of their plan with this form.

Will you need help with transportation to your appointment?

What happens now?

Once we receive your form, we will review your child's information and reach out by phone to schedule within 30 days. Please feel free to call or text us to let us know you submitted an intake form- this may speed up the process.

Notes/Comments/Questions