Adams Pediatrics
JAMI ADAMS M.D. P.A.

Jami Adams, M.D., P.A.
6300 Regional Plaza, Suite 250
Abilene, TX, 79606-5224
(325) 695-1600 / Fax (325) 695-1601

Patient Information

Last Name	**First Name**	**Middle Name**	**Suffix**: ❑ None ❑ Jr ❑ Sr ❑ I ❑ II ❑ III
Name child goes by	**Gender** ❑ M ❑ F	**Social Security No.**	**Date of Birth**
Race: ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or other Pacific Islander ❑ White ❑ Other			
Current Address		**Zip Code**	**City** / **State**
Home Phone	**Cell Phone**	**Work Phone**	**E-mail**
Preferred Contact Method(s): ❑ Home Phone ❑ Cell Phone ❑ Work Phone ❑ Text message ❑ E-mail			

Sibling Information (Use back of page for additional siblings)

Last Name	First Name	Middle Name	Date of Birth	Gender	Social Security Number
				❑ M ❑ F	
				❑ M ❑ F	

Patient's Primary Responsible Party Information

Last Name	**First Name**		**Middle Name**
Relationship to patient: ❑ Mother ❑ Father ❑ Legal guardian	**Date of Birth**	**Social Security Number**	**Marital Status:** ❑ Married ❑ Divorced ❑ Separated ❑ Single ❑ Widowed
Home Phone (❑ same as patient)	**Cell Phone**		**Work Phone**
Current Address (❑ same as patient)	**Zip Code**	**City**	**State**

Patient's Secondary Responsible Party Information

Last Name	**First Name**		**Middle Name**
Relationship to patient: ❑ Mother ❑ Father ❑ Legal guardian	**Date of Birth**	**Social Security Number**	**Marital Status:** ❑ Married ❑ Divorced ❑ Separated ❑ Single ❑ Widowed
Home Phone (❑ same as patient)	**Cell Phone**		**Work Phone**
Current Address (❑ same as patient)	**Zip Code**	**City**	**State**

Primary Medical Insurance Information (❑ Check here if you have no primary insurance)

Insurance Company (❑ Medicaid)	**Policy Holder**	**Policy Holder Date of Birth**	
Policy Number/Social Security Number of Policy Holder	**Group Number (if applicable)**	**Date Effective (if known)**	**Relationship to Patient**

Secondary Medical Insurance Information (❑ Check here if you have no secondary insurance)

Insurance Company (❑ Medicaid)	**Policy Holder**	**Policy Holder Date of Birth**	
Policy Number/Social Security Number of Policy Holder	**Group Number (if applicable)**	**Date Effective (if known)**	**Relationship to Patient**

Assignment of Benefits ❖ Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to JAMI ADAMS, M.D., P.A., and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.
I further agree that a photocopy of this agreement shall be as valid as the original.

SIGNATURE: _____ DATE: _____

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FORMULARY BENEFITS DATA CONSENT FORM

Formulary Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

By signing below I give permission for Adams Pediatrics to access my child's pharmacy benefits data electronically through Rx.Hub. This consent will enable Adams Pediatrics to:

- Determine the pharmacy benefits and drug copays for a patient's health plan.
- Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medications prescribed for a patient by any provider.

In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using Rx.Hub.

Child's Name (PRINTED): _____ Date of Birth: _____/_____/_____

Child's Name (PRINTED): _____ Date of Birth: _____/_____/_____

Child's Name (PRINTED): _____ Date of Birth: _____/_____/_____

Child's Name (PRINTED): _____ Date of Birth: _____/_____/_____

_____ _____/_____/_____

Signature of Parent, Guardian, or Legal Representative **Date**

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Acknowledgment of Receipt of Notice of Privacy Practices:

_____ Initial **I have received this office's Notice of Privacy Practices, which explains how my child(ren)'s medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.**

Patient Privacy Questionnaire:

I. Please list the family members or other persons, if any, whom we may inform about your child/children's general medical condition and diagnosis (including treatment, payment, and health care operations:)

_____

_____

II. Please print the address of where you would like your **billing statements** and/or **correspondence** from our office to be sent if other than your home:

_____

_____

III. Please print the telephone number where you want to receive calls about your child/children's appointments, lab and x-ray results, or other health care information if other than your home phone number: _____

Initial _____ ***I am fully aware that a cell phone is not a secure and private line.***

IV. Can confidential messages (e.g., appointment reminders) be left on your telephone answering machine or voicemail? ❑ Yes ❑ No

_____ _____
Signature of Parent or Legal Guardian Date

_____ _____
Print Name of Parent or Legal Guardian Legal relation to child(ren)

List name(s) of child(ren) covered by this form:

_____ _____

_____ _____

_____ _____

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Medical Photography Release/Approval:

This clinic is strongly dedicated to the use of the most advanced technologies available in giving and documenting your medical care. To this end, we have invested in electronic medical records. This means that all items traditionally in a paper format will be obtained, stored, and cataloged digitally. This record will also include the digital photo of your child(ren) for identification by Dr. Adams and the staff. Any lesions, procedures, or other items which may be documented visually, will also be stored and reproduced in this manner. If you have no objection to the use of these photos we would greatly appreciate your signature below.

I hereby authorize Jami Adams, M.D., P.A., and its representatives to obtain and reproduce photographs of my child(ren)'s likeness(es) for purposes of medical records. I also approve of the use and reproduction of clinical photos for referral, coding, charting, and educational purposes.

Signature of Parent or Legal Guardian	Date
Print Name of Parent or Legal Guardian	Legal relation to child(ren)

List name(s) of child(ren) covered by this release:

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Pediatric Health History Form

Child's Name: | **Child's Birthdate:** | **Child's Previous Doctor:**

Current Problems/Concerns:

Allergies/Reactions to Medicines or Vaccines:

Current Medicines:

Pregnancy & Birth:

Any problems with the pregnancy? ❑ No. ❑ Yes (please specify:)

Delivered by: ❑ vaginal birth ❑ caesarian (please explain why:)

Birth weight: | Birth length:

Immunizations/exposures:

Are your child's immunizations up to date? ❑ No ❑ Yes ***Please bring your child's shot record.***

Does your insurance cover immunizations? ❑ No ❑ Yes ***(If "no," your child may be eligible for free immunizations.)***

Do any household members smoke? ❑ No ❑ Y es Any concerns about lead exposure? (old home/plumbing/peeling paint) ❑ No ❑ Yes

Past Medical History: Does your child have any of the following conditions? Please check all that apply:

❑ Asthma / hay fever / eczema	❑ Broken bones	❑ Frequent ear infections	❑ Chicken pox
❑ Attention problems	❑ Problems going potty	❑ Pneumonia	❑ Obesity
❑ Croup	❑ Anemia	❑ RSV	❑ Urinary tract infections

Past Surgical History: Has your child had any operations such as circumcision, hernia repair, or tonsillectomy? ❑ No ❑ Yes (please explain):

Family History: Please check any family history of the following and indicate who has/had the condition
(M = mother, F = father, B = brother, S = sister, G = grandparent, E = extended family):

	M	F	B	S	G	E		M	F	B	S	G	E
❍ Alcoholism/drug abuse	❑	❑	❑	❑	❑	❑	❍ Bleeding / clotting problems	❑	❑	❑	❑	❑	❑
❍ Heart disease or stroke	❑	❑	❑	❑	❑	❑	❍ Kidney disease	❑	❑	❑	❑	❑	❑
❍ Cancer	❑	❑	❑	❑	❑	❑	❍ Asthma / hay fever / eczema	❑	❑	❑	❑	❑	❑
❍ Seizures	❑	❑	❑	❑	❑	❑	❍ High blood pressure	❑	❑	❑	❑	❑	❑
❍ Inherited/genetic diseases	❑	❑	❑	❑	❑	❑	❍ Birth defects	❑	❑	❑	❑	❑	❑
❍ Thyroid disease	❑	❑	❑	❑	❑	❑	❍ Diabetes	❑	❑	❑	❑	❑	❑
❍ Psychiatric disorders	❑	❑	❑	❑	❑	❑							

Social History: Please list the names of all people who live with the child

Name	Age	Relationship	Name	Age	Relationship

The child's parents are: ❑ married. ❑ unmarried but living together. ❑ separated. ❑ divorced.

Mother's occupation: | Father's occupation:

Child care situation: ❑ lives with parents ❑ lives with others (please explain):

Is violence at home a concern? ❑ No ❑ Yes Are there guns at home? ❑ No ❑ Yes

School History:

Does your child attend preschool/school? ❑ No ❑ Yes Grade: _____ School: _____

Any concerns about school performance? ❑ No ❑ Yes (if yes, please explain:)

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
IMMUNIZATION REGISTRY (ImmTrac)
MINOR CONSENT FORM

ImmTrac
Texas Immunization Registry

(Please print clearly)

For Clinic/Office Use

Child's Last Name

Child's First Name

Child's Middle Name

Child's Date of Birth / / ***Children under 18 years only.***

Child's Gender: ☐ **Male** ☐ **Female**

Child's Address

Apartment #

Telephone

City

State

Zip Code

County

Mother's First Name

Mother's Maiden Name

ImmTrac, the Texas immunization registry, is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates and stores your child's (under 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac. Doctors, public health departments, schools and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed.

The Texas Department of State Health Services encourages your voluntary participation in the Texas immunization registry.

Consent for Registration of Child and
Release of Immunization Records to Authorized Entities

I understand that, by granting the consent below, I am authorizing release of the child's immunization information to DSHS and I further understand that DSHS will include this information in the state's central immunization registry ("ImmTrac"). Once in ImmTrac, the child's immunization information may by law be accessed by:

- a public health district or local health department, for public health purposes within their areas of jurisdiction;
- a physician, or other health care provider legally authorized to administer vaccines, for treating the child as a patient;
- a state agency having legal custody of the child;
- a Texas school or child care facility in which the child is enrolled;
- a payor, currently authorized by the Texas Department of Insurance to operate in Texas, regarding coverage for the child.

I understand that I may withdraw this consent to include information on my child in the ImmTrac Registry and my consent to release information from the Registry at any time by written communication to the Texas Department of State Health Services, ImmTrac Group – MC 1946, P.O. Box 149347, Austin, Texas 78714-9347.

By my signature below, I GRANT consent for registration. I wish to INCLUDE my child's information in the Texas immunization registry.

Parent, legal guardian or managing conservator: _____
Printed Name

_____ _____
Date **Signature**

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)

Questions? (800) 252-9152 • (512) 458-7284 • www.ImmTrac.com
Texas Department of State Health Services • ImmTrac Group – MC 1946 • P.O. Box 149347 • Austin, TX 78714-9347

Stock No. C-7
Revised 05/27/11

TEXAS Department of State Health Services

PROVIDERS REGISTERED WITH ImmTrac *– Please enter client information in ImmTrac and* ***affirm*** *that consent has been granted.*
DO NOT fax to ImmTrac. Retain this form in your client's record.

TEXAS VACCINES FOR CHILDREN (TVFC) PROGRAM
PATIENT ELIGIBILITY SCREENING RECORD

CLINIC USE ONLY:
TVFC Eligible:
☐ Yes ☐ No

_____
Screener's Initials

A record of all children 18 years of age or younger who receive immunizations through the Texas Vaccines for Children Program must be kept in the health care provider's office. The record may be completed by the parent, guardian, individual of record, or by the health care provider. TVFC eligibility screening must take place with each immunization visit to ensure the child's eligibility status has not changed. This same record will satisfy the requirements for all subsequent vaccinations, as long as the child's eligibility has not changed. If patient eligibility changes, a new form must be completed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccines under the TVFC Program.

Date of Screening: _____
mm/dd/yyyy

Child's Name: _____
Last Name First Name MI

Child's Date of Birth: _____ Age: _____
mm/dd/yyyy

Parent/Guardian/Individual of Record: _____
Last Name First Name MI

Provider's Name/Clinic's Name: Jami Adams, MD, PA Phone Number: (325) 695-1600
Area Code + number

Please check the first category that applies; check only one.

(a) ☐ Is enrolled in Medicaid, or

_____ _____
Medicaid Number: Date of Eligibility (mm/dd/yyyy)

(b) ☐ Is a patient who receives benefits from the Children's Health Insurance Plan (CHIP), or

_____ _____
CHIP Number: Date of Eligibility (mm/dd/yyyy)

(c) ☐ Is an American Indian, or

(d) ☐ Is an Alaskan Native, or

(e) ☐ Does not have health insurance (uninsured), or

(f) ☐ Is underinsured:

- ☐ 1) has commercial (private) health insurance, but coverage does not include vaccines; or
- ☐ 2) insurance covers only selected vaccines (TVFC-eligible for non-covered vaccines only); or
- ☐ 3) insurance caps vaccine coverage at a certain amount. Once that coverage amount is reached, the child is categorized as underinsured.

(g) ☐ Has private insurance that covers vaccines:

Name of Insurer: _____ Insurer Contact Number: (_____) _____
Area Code + number

Policy/Subscriber Number: _____ Group Number (if applicable): _____

NOTE: Knowingly falsifying information on this document constitutes fraud. By signing this form, I hereby attest that the above information is true and correct. I declare that the person named above is an authorized person and is eligible to receive TVFC vaccines.

Signature: _____ Date: _____
(mm/dd/yyyy)

With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)