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

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)