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: _____