Dr. Jamie Waldrep MD
250 Strickland Drive
Orange, Texas 77630
Ph: 409.883.7900 | Fx: 409.883.7909
Web: www.drjamiewaldrepmd.com

NEWBORN NEW PATIENT APPLICATION

1. **Complete the ENTIRE application. Please understand that the application will not be processed if all forms are not entirely completed.**
2. **On the "HIPAA Privacy Acknowledgement" form, be sure to list anyone who can bring your child to their appointments. They will need a photo ID.**
3. **The both Medical Records Release must be signed and dated.**
4. **A copy of the insurance card and the newborn hospital records. (if already born)**
5. **If your baby has not arrived as of yet, leave the babies information blank and return the application to be processed prior to the baby being born.**

The application will be reviewed by Dr. Waldrep and you will be contacted for an appointment if your application has been approved by the doctor.

****NOTE** OUR OFFICE POLICY REQUIRES THE CUSTODIAL PARENT TO ATTEND FIRST OFFICE VISIT AND ALL WELL CHILD EXAMS.**

WE DO NOT ACCEPT WALK-INS. WE WORK BY APPOINTMENT ONLY IF OVER 15 MINUTES LATE, YOUR APPOINTMENT WILL BE RESCHEDULED

Hospital Delivering at: _____

OB Doctor: _____

Baby's already born: **Breast feed?** **Bottle Feed?**

Does your baby have Jaundice? **Yes** **No**

DR. JAMIE WALDREP, MD
250 STRICKLAND, ORANGE, TEXAS 77630
409-883-7900, FAX 409-883-7909

PATIENT INFORMATION FORM

CHILD'S NAME		SEX: male female
DATE OF BIRTH:	CHILD'S SS#:	RACE:
ETHNIC GROUP: ◯HISPANIC/LATINO ◯ NON HISPANIC/LATINO ◯ OTHER ◯ DECLINE		
LANGUAGE:		

MOTHER'S NAME:			SS #:
MOTHER'S DATE OF BIRTH:			
ADDRESS:			CITY,STATE ZIP:
HOME PHONE ( )	WORK PHONE ( )	CELL PHONE ( )	
MOTHER'S PLACE OF EMPLOYEMENT:			
MOTHER'S EMAIL ADDRESS:			

FATHER'S NAME:			SS #:
FATHER'S DATE OF BIRTH:			
ADDRESS:			CITY,STATE ZIP:
HOME PHONE ( )	WORK PHONE ( )	CELL PHONE ( )	
FATHER'S PLACE OF EMPLOYEMENT:			
FATHER'S EMAIL ADDRESS:			

PRIMARY INSURANCE:

CARRIER NAME:		POLICY ID #:
INSURED?: MOTHER	FATHER	GROUP #

SECONDARY INSURANCE:

CARRIER NAME:		POLICY/ID #:
INSURED?: MOTHER	FATHER	GROUP #

SIBLINGS (names and ages)

CHILD'S PAST MEDICAL HISTORY:

HOSPITALIZATIONS: (age and reason)	
SURGERIES:	PERFORMING PHYSICIAN:
CURRENT MEDICATIONS:	ALLERGIES:
ONGOING MEDICAL PROBLEMS:	

TOBACCO USE IN HOME?	YES	NO	ANIMALS IN HOME?	YES	NO
GUNS IN HOME?	YES	NO	TRAVEL OUTSIDE U.S.?	YES	NO

PARENT/GUARDIAN SIGNATURE _____ DATE _____

PAST MEDICAL HISTORY

Dr. Jamie Waldrep MD, 250 Strickland, Orange Texas 77630

PATIENT NAME:	DOB:

Is your child allergic to any medications? (Prescription or Over the Counter) If YES, Please list:	YES	NO
Is your child taking any current medications? If Yes, Please list:	YES	NO

BIRTH INFORMATION:

What was the Gestional Age of your baby when born? (how many weeks)		
Was the birth a Vaginal delivery or C-Section	Vaginal	C-Section
What hospital born in?		
Who was mother's OB doctor?		
Birth Weight _____ LBS _____ OZ	Birth Length _____ Inches	
What was results of hearing test done at birth hospital?		
What was results of 1st Newborn Screen?		
What was results of 2nd Newborn Screen?		
Any complications during pregnancy or birth? Please list:		

PAST MEDICAL HISTORY:

Does your child have history of frequent ear infections?	YES	NO
Does your child have Asthma?	YES	NO
Does your child have history of frequent Throat problems or Strep?	YES	NO
Does your child have history of/currently have Acid Reflux?	YES	NO
Has your child ever had Chicken Pox?	YES	NO
If you ansered YES to any of the following, please explain below. (Please include frequency of problem, dates, etc.)		
Has your child had any ER visits? If yes, please explain.	YES	NO
Has your child had any Hospitalizations? If yes, please explain.	YES	NO
Has your child had any Surgeries? (i.e. Circumcision, ear tubes, etc.) If Yes, please explain.	YES	NO

FAMILY MEDICAL HISTORY:

MEDICAL HISTORY OF: (Example: Mother of Child: Diabetes, High Blood Pressure, etc.)
Any illness of Mother of Child:
Any illness of Father of Child:
Any illness of Maternal Grandmother:
Any illness of Maternal Grandfather:
Any illness of Paternal Grandmother
Any illness of Paternal Grandfather:
SOCIAL HISTORY:
Parents Marital Status:
Mother's Occupation:
Father's Occupation:
Who lives in child's household? (example: mom, dad, 2 sisters, 1 brother, etc.)

Does anyone smoke in the household? (inside house or outside) Who? (example: mom, dad, grandma?)	YES	NO
Is your child in daycare?	YES	NO

VACCINE AUTHOIZATION FORM

Dr. Jamie M. Waldrep MD, 250 Strickland Drive, Orange, Texas 77630

*Patient: _____ * Date of Birth: _____

By signing below, I authorize Dr. Jamie M. Waldrep, MD to give my child age-appropriate Immunizations as described by the American Academy of Pediatrics and the State of Texas.

The following is the recommended immunization schedule as directed by the State of Texas and followed by our office. I understand that my child is behind on vaccines and I agree to the catch-up schedule which is as follows:

First appointment: Vaxelis 2nd dose, Hep A 1st dose, MMRV 1st dose, Prevnar 2nd dose.
4 months after first dosing: Vaxelis 3rd dose, Prevnar 3rd dose, Acthib 3rd dose.
6 months after second dosing: Hep A 2nd dose, DTaP 4th dose, Varicella 2nd dose.

I understand if I miss any appointments for catch up vaccines, my children will be discharged as patients.

Under One year of age:

- ✓ 3 DTaP
- ✓ 3 Polio
- ✓ 3 Hepatitis B
- ✓ OR 3 Pedirix which contains the above
- ✓ 3 HIB
- ✓ 3 Prevnar

One to two years of age:

- ✓ 1 DTaP
- ✓ 1 HIB
- ✓ 1 Prevnar
- ✓ 1 MMR
- ✓ 1 Varicella (at age 1 and 1 at 3 months following 1st immunization)
- ✓ 1 Hepatitis A (at age 2) and 1 Hepatitis A 6 months-12 months following 1st immunization

At the age of 4

- ✓ 1 DTaP
- ✓ 1 Polio
- ✓ 1 MMR

At age 9 to 10 years 1 TDaP
At Age 9 Years HPV is offered
At age 12 years and 16 years Meningitis
Annual Influenza Vaccine

By signing below, I am consenting for my child to have the above-named shots as needed to maintain up to date immunizations. This authorization will remain in effect unless withdrawn in writing by me.

I understand that I will be provided a copy of the appropriate Centers of Disease Control Prevention Vaccine information material(s) and will read, or have had explained to me, information about the disease and the vaccines listed above. I will have a chance to ask questions that will be answered to my satisfaction. I believe I understand the benefits and risks of the vaccines cited, and ask that the vaccine(s) listed above be given to me or persons authorized by me.

* _____ * _____

Parent Signature Date

PATIENT FINANCIAL POLICY

Dr. Jamie M. Waldrep MD, 250 Strickland Drive, Orange, Texas 77630

PATIENT NAME: _____ **DATE OF BIRTH:** _____

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service.

- We have made prior arrangements with insurers and health plans to accept an assignment of benefits. This means we will bill those plans for which we have an agreement and will only require you to pay the copayment/coinsurance amounts due at the time of service. This office's policy is to collet this payment when you arrive for your appointment.

- In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

- I understand that I will be dismissed if I have more than 3 no show appointments. I must call at least 24 hours prior to the scheduled appointment or the scheduled appointment will be considered a no show. I will have my child at every well exam; 2 month, 4 month, 6 month, 9 month, 12 month, 15 month, 18 month, 24 month, 3 -18 year.

I, the undersigned, certify that I have insurance coverage and assign directly to Dr. Jamie Waldrep, MD all insurance benefits, if any, for services rendered. I understand I am financially responsible and must provide all active insurance information, if any, and I understand I am financially responsible for all charges whether or not paid for by insurance.

I hereby authorize Dr. Jamie Waldrep, MD to release all information necessary to secure the payment of benefits.

I authorize the use of this signature on all insurance submissions.

I authorize Dr. Jamie Waldrep M.D. and staff to treat the above-mentioned child when brought to this office for illness or well exam.

I hereby assign, transfer, and set over to Dr. Waldrep all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given me revoking this authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I have read this office's guidelines with the patient's rights and responsibilities. I have been informed that these documents are available and a copy can be given to me at my request.

***SIGNATURE OF PARENT/LEGAL GUARDIAN:** _____

DATE: _____

HIPAA PRIVACY ACKNOLEGEMENT

Dr. Jamie M. Waldrep MD, 250 Strickland Drive, Orange, Texas 77630

***DATE:** _____

I, _____, the parent/legal guardian of _____ do hereby authorize the following people to request medical care for my child in my absence. This also includes X-ray, anesthetic, medical and surgical diagnosis or treatment which is deemed advisable by and is to be rendered under the general or special supervision of any physician or surgeon licensed under the provisions of the Medical Practice Act on the medical staff of any hospital whether or not such diagnosis or treatment is tendered but is given to provide authority and power on the part of the aforesaid agents to give specific consent to any and all such diagnosis, treatment or hospital care which aforementioned physician in the exercise of his or her best judgment may deem advisable. I hereby authorize any hospital which had provided treatment to the above-named minor to surrender physical custody of medical records to the above-named agents upon the completion of treatment. Also, I understand that I can request a copy of or to see my medical records by signing the Medical Records Request.

***I authorize the following people to request medical care for my child in my absence:**

Name: _____ **Phone #:** _____

DOB: _____ **Relationship to child:** _____

Name: _____ **Phone #:** _____

DOB: _____ **Relationship to child:** _____

Name: _____ **Phone #:** _____

DOB: _____ **Relationship to child:** _____

Name: _____ **Phone #:** _____

DOB: _____ **Relationship to child:** _____

Name: _____ **Phone #:** _____

DOB: _____ **Relationship to child:** _____

I authorize Dr. Jamie Waldrep M.D. and staff to treat the above-mentioned child when brought to this office for illness or well exam.

***SIGNATURE OF PARENT/LEGAL GUARDIAN:** _____

***DATE:** _____

DR. JAMIE WALDREP M.D.
250 Strickland Drive, Orange, Texas 77630
409-883-7900, 409-888-498-3122
Email: off.manager@drjamiewaldremd.com
Website: drjamiewaldrepmd.com

APPOINTMENT POLICY STATEMENT

Our office requires that you give at least 24-hours advance notice if you plan to miss a scheduled appointment. We look forward to providing good care to your child(ren) but our office cannot operate if you do not notify us that you do not plan to attend your appointments at least 24 hours in advance. We will give you a reminder card with the date and time of the appointment. You will receive a text message or phone reminder at 7 days and 24 hours prior to your appointment. If there is not a call to cancel at least 24 hours prior to your appointment there will be a $30.00 charge for no show and late cancelation.

_____ _____

Parent Signature **Date**

MEDICAL RECORDS RELEASE FORM

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

HIV/AIDS: I consent to release any positive or negative test results for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical records. **Initial:** _____ **Date:** _____

***PATIENT NAME:** _____ ***DOB:** _____

PREVIOUS DOCTOR: _____ PHONE #: _____

I give authorization to release my protected health information to:

JAMIE WALDREP MD

250 STRICKLAND DRIVE

ORANGE, TEXAS 77630

OFFICE: 409-883-7900 FAX: 1-888-498-3122

Please forward the requested information listed below to our office. The purpose for this release of information is for continuance of care:

_____

_____

_____

***PATIENT/PARENT/GUARDIAN SIGNATURE:** _____

***DATE:** _____

OFFICE USE ONLY

Please fax shot record(s) and if medical records are more than 10 pages please mail them!

Faxed by: _____ on _____ at ____:_____

NEWBORN MEDICAL RECORDS RELEASE FORM

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

FACILITY NAME: _____ **Number:** _____

HIV/AIDS: I consent to release any positive or negative test results for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical records. **Initial:** _____ **Date:** _____

***PATIENT NAME:** _____ ***DOB:** _____

***MOTHERS NAME:** _____ ***DOB:** _____

I give authorization to release mine and my child's protected health information to:

JAMIE WALDREP MD

250 STRICKLAND DRIVE

ORANGE, TEXAS 77630

OFFICE: 409-883-7900 **FAX: 888-498-3122**

Please forward the requested information listed below to our office. The purpose for this release of information is for continuance of care:

Baby's Discharge Summary, Admit note, Blood type, Hepatitis B Vaccine, Bilirubin Report, X-Ray, Hearing Screen, also [Discharge Instructions (Christus STE)]

Mother's Hepatitis B, HIV, Blood Type & Syphilis Lab work

***PATIENT/PARENT/GUARDIAN SIGNATURE:** _____

***DATE:** _____

OFFICE USE ONLY

Please fax shot record(s) and if medical records are more than 10 pages please mail them!

Faxed by: _____ on _____ at ____:_____

TEXAS Health and Human Services | Texas Department of State Health Services

Texas Immunization Registry (ImmTrac2)

Minor Consent Form

A parent, legal guardian, or managing conservator must sign this form if the client is younger than 18 years of age.

Child's First Name _____ Child's Middle Name _____ Child's Last Name _____

Child's Date of Birth (mm/dd/yyyy) ____/____/____ Child's Sex: ☐ Male ☐ Female Telephone ____-____-____ Email address _____

Child's Address _____ Apartment # / Building # _____

City _____ State _____ Zip Code _____ County _____

Mother's First Name _____ Mother's Maiden Name _____

Race (select all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African-American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race
☐ Recipient Refused

Ethnicity (select only one)

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Other

The Texas Immunization Registry (ImmTrac2) is a free service of the Texas Department of State Health Services (DSHS). ImmTrac2 is a secure and confidential service that consolidates and stores your child's (younger than 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac2. Doctors, public health departments, schools, and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed. For more information, see Texas Health and Safety Code § 161.007 (d). *https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.007*.

Consent for Registration of Child and Release of Immunization Records to Authorized Persons/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 ImmTrac2. Once in ImmTrac2, 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; and 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 at any time by submitting a completed Withdrawal of Consent Form in writing to the Texas DSHS, ImmTrac2.

State law permits the inclusion of immunization records for first responders and their immediate family members in ImmTrac2.
A "first responder" is defined as a public safety employee or volunteer whose duties include responding rapidly to an emergency.
An "immediate family member" is defined as a parent, spouse, child, or sibling who resides in the same household as the first responder.
For more information, see Texas Health and Safety Code § 161.00705. *https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.00705*.

Please mark the box below to indicate whether your child is an immediate family member of a first responder.
☐ **I am an IMMEDIATE FAMILY MEMBER of a first responder.**

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 _____ Signature _____ Date _____

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.texas.gov* for more information. (Reference: Tex. Gov. Code, § 552.021, 552.023, 559.003, and 559.004)

PROVIDERS REGISTERED WITH ImmTrac2: Please enter client information in the Texas Immunization Registry and affirm that consent has been granted. **DO NOT** fax to **ImmTrac2**. **Retain this form in your client's record.**

Questions? Tel: 800-252-9152 • Fax: 512-776-7790 • *https://www.dshs.texas.gov/immunize/immtrac/*
Texas Department of State Health Services • Immunizations • Texas Immunization Registry – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347