PRENATAL PATIENT REGISTRATION FORM

☐ NEW PATIENT – NEW FAMILY ☐ NEW PATIENT – ESTABLISHED FAMILY

☐ DR. JOHN CLARK ☐ DR. ZULMA LARACUENTE

PATIENT INFORMATION

PATIENT'S LAST NAME	DUE DATE

OBSTETRICIAN	HOSPITAL

PARENT/GUARDIAN INFORMATION

PRIMARY PARENT / GUARDIAN'S NAME (LAST, FIRST, MIDDLE)	RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER

MAILING ADDRESS	CITY	STATE	ZIP

HOME PHONE	CELL PHONE	WORK PHONE	EMPLOYER

SECONDARY PARENT / GUARDIAN'S NAME (LAST, FIRST, MIDDLE)	RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER

MAILING ADDRESS	CITY	STATE	ZIP

HOME PHONE	CELL PHONE	WORK PHONE	EMPLOYER

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME	POLICY EFFECTIVE DATE	POLICY NUMBER	GROUP NUMBER

SUBSCRIBER'S NAME (LAST, FIRST, MIDDLE)	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER

RELATIONSHIP TO PATIENT	EMPLOYER

SECONDARY INSURANCE COMPANY NAME	POLICY EFFECTIVE DATE	POLICY NUMBER	GROUP NUMBER

SUBSCRIBER'S NAME (LAST, FIRST, MIDDLE)	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER

RELATIONSHIP TO PATIENT	EMPLOYER

OTHER CHILDREN IN FAMILY

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	IS THIS CHILD A PATIENT OF PREMIER PEDIATRICS?
		☐ YES, CURRENT PATIENT ☐ YES, FORMER PATIENT ☐ NO
NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	IS THIS CHILD A PATIENT OF PREMIER PEDIATRICS?
		☐ YES, CURRENT PATIENT ☐ YES, FORMER PATIENT ☐ NO
NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	IS THIS CHILD A PATIENT OF PREMIER PEDIATRICS?
		☐ YES, CURRENT PATIENT ☐ YES, FORMER PATIENT ☐ NO

ASSIGNMENT OF BENEFITS AND AUTHORIZATION FOR INFORMATION RELEASE

- I understand that it is my responsibility to contact my insurance company and add this child to that policy within 30 days of his/her birth.
- I hereby assign and authorize payment of insurance benefits otherwise payable directly to Premier Pediatrics for my child's office and/or hospital services which are not paid by me at the time of service.
- I hereby authorize Premier Pediatrics to provide treatment for my child and to release any and all information pertaining to office and/or hospital services rendered to him/her by said practice, including any previous diagnosis and treatment rendered to him/her by physicians, hospitals, and/or other medical facilities/personnel.
- I understand that Premier Pediatrics will not file Medicaid as a secondary insurance for any office services rendered to my child; if my primary insurance does not pay in full for the charges incurred, it is my responsibility to pay the remaining balance.
- I understand that I am ultimately responsible for payment of any and all charges for treatment rendered to my child, and if this assigned claim is rejected, modified, or not paid within a reasonable amount of time after it has been filed, it will be my responsibility to pay any unpaid charges in full.

Parent / Guardian Signature _____ Date _____

MOTHER'S MEDICAL HISTORY

Past Medical History (e.g. significant illnesses, surgeries, injuries, hospitalizations, allergies, etc.)

_____

_____

_____

Blood Type/RH _____ Number of Pregnancies, including present _____

Number of Living Children _____

Number of Miscarriages _____

PREVIOUS PREGNANCY(IES)

_____

Year of Birth Sex Birth Weight Special Problems

_____

Year of Birth Sex Birth Weight Special Problems

_____

Year of Birth Sex Birth Weight Special Problems

CURRENT PREGNANCY

During this pregnancy, do or did you have:

☐ Fever ☐ Diabetes ☐ Excess Weight Gain

☐ High Blood Pressure ☐ Infections ☐ Other Concerns _____

☐ Rashes ☐ Bleeding Exposure to: ☐ Cigarette Smoke ☐ Alcohol ☐ Illicit Drugs

Medications _____ _____ X-rays/Injuries _____

Name Date Name Date X-ray/Injury Date

LABOR AND DELIVERY

Plans for Labor and Delivery (childbirth classes, father's participation, preferred anesthesia)

_____

_____

_____

Cesarean Section Planned? ☐ No ☐ Yes If yes, why? _____

Feeding Method ☐ Breast ☐ Bottle ☐ Undecided (For Boys) Circumcision Planned? ☐ Yes ☐ No ☐ Undecided

FAMILY MEDICAL HISTORY

Father's Blood Type/RH _____

Family Medical History (e.g. diabetes, frequent miscarriages, seizures, bleeding disorder, serious anemia, muscular diseases, newborns with serious difficulties, twins, etc.)

_____

_____

_____