**Patient Last Name:** _____ **DOB:** _____

**First** **Middle** **Due Date:**

ChristianaCare™

**OB Physician Practice:**
**Primary Care Doctor:**
**Date:**

It is very important that you provide complete and accurate information to all of the questions. The information you provide below will be used to create your child's birth certificate. The birth certificate is a document that will be used for legal purposes to prove your child's age, citizenship and parentage.

In addition to the birth certificate the information being used for personal legal purposes, information from the birth certificate is also used by health and medical researchers to study and improve the health of mothers and newborn babies. Items such as parent's education and race will be used for studies but will not appear on copies of the birth certificate issued to you or your child. You may be asked to update or verify this information numerous times throughout your pregnancy – this is for your safety and to ensure your medical record is accurate.

**INFORMATION ON MOTHER (*WOMAN GIVING BIRTH TO THIS CHILD*)**
**PLEASE PRINT CLEARLY** **What is your email address**: _____

1. **What is your current legal name?**

_____ _____ _____ _____
First Middle Last Suffix (Jr., III, etc.)

2. **What name did you use prior to your first marriage?** (your *maiden* name) (Mother/3)

_____ _____ _____ _____
First Middle Last Suffix (Jr., III, etc.)

3. **What is your date of birth?**

_____ _____ _____
Month Day Year

4. **What is your Social Security Number?**

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | ---- | | | ---- | | | | |

**5. In what State, U.S. territory, or foreign country were you born?**

Please specify one of the following:

State _____ *or*
U.S. Territory, i.e., Puerto Rico, U.S. Virgin Islands, Guam, American Samoa or Northern Marinas _____
*or* Foreign country _____

**What is your Preferred Language?** _____ **Religious Prefence:** _____

**6. Where do you usually live – that is – where is your household/residence located?**

Complete number and street: _____ Apartment # _____
(Do not enter rural route numbers/P.O. Boxes)

City, Town, or Location: _____

County: _____ State: _____ Zip Code: _____

If not United States, *country* _____

**Patient Last Name:** _____ **DOB:** _____

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**7. Is this household inside city limits** (inside the incorporated limits of the city, town, or location where you live)?

CHECK ONE: ☐ Yes ☐ No ☐ Don't Know

**8 What is your MAILING address?**

**Home Phone:** (_____)_____ **Cell Phone:**(_____)_____

☐ Same as residence

Complete number and street: _____ Apartment # _____
(Do not enter rural route numbers/P.O. Boxes)

City, Town, or Location: _____

County: _____ State: _____ Zip Code: _____

If not United States, *country* _____

| **Employment Information** ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Other:_____ | |
|---|---|
| **Patient's Employer Name & Occupation** | |

9. **What is the highest level of schooling that you will have completed at the time of delivery?** (Check the box that best describes your education. If you are currently enrolled, check the box that indicates the previous grade or highest degree received)?

☐ 8th grade or less
☐ 9th – 12th grade, no diploma
☐ High school graduate or GED completed
☐ Some college credit, but no degree
☐ Associate degree (e.g. AA, AS)
☐ Bachelor's degree (e.g. BA, AB, BS)
☐ Master's degree (e.g. MA, MS, MEng, Med, MSW, MBA)
☐ Doctorate (e.g. PhD, EdD) or Professional degree (e.g. MD, DDS, DVM, LLB, JD)

10. **Did you receive WIC** (Women, Infants & Children) **food for yourself because you were pregnant with this child**?

☐ No ☐ Yes

11. **Are you Spanish/Hispanic/Latina?** If not Spanish/Hispanic/Latina, check the "No" box. If Spanish/Hispanic/Latina, check the appropriate box

☐ No, not Spanish/Hispanic/Latina
☐ Yes, Mexican, Mexican American, Chicana
☐ Yes, Puerto Rican
☐ Yes, Cuban
☐ Yes, other Spanish/Hispanic/Latina (e.g. Spaniard, Salvadoran, Dominican, Colombian)
(Specify)_____

12. **What is your race?** (Please check one or more races to indicate what you consider yourself to be.)

☐ White
☐ Black or African American
☐ Chinese
☐ American Indian or Alaska Native (name of enrolled or principal tribe) _____
☐ Japanese
☐ Asian Indian
☐ Guamanian or Chamorro
☐ Vietnamese
☐ Filipino
☐ Native Hawaiian
☐ Samoan
☐ Korean
☐ Other Asian (specify) _____
☐ Other Pacific Islander (specify) _____
☐ Other (specify) _____

13. **Do you want a Social Security Number issued for your baby?**

☐ Yes [*Please sign question 15*] ☐ No

**Patient Last Name:** _____ **DOB:** _____

**First** **Middle** **Due Date:**

14. I request the Social Security Administration assign a Social Security number to the child named on this form and authorize the State to provide the Social Security Administration with the information from this form which is needed to assign a number. (Either biological parent, or the legal guardian, may sign.)

Signature of infant's biological parent or legal guardian _____Date _____

15. Mother's Domestic Status - **Have you ever been married?** (At birth, conception, or any time between) **The marital status must be provided.** Please check the box that best describes your marital status

**If you are currently married or separated**, your current husband is considered to be the legal father of the child (DE Law Title 13, Chapter 8, Sub Chapter II, §8-204). If your husband is not the biological father of the child, a court determination of paternity is required to add the father's name to the birth certificate.)

☐**Married** – [Read message above and please go to question 16]

☐**Separated** – [Read message above and Please go to question 16]

☐**Married, Husband Info Refused** – If husband's information is refused the father's information will not be listed on the birth certificate.

☐**Divorced/Widowed**

Please provide the date you became divorced or widowed. _____/_____/_____

MM / DD / YYYY

☐**Same Sex Marriage** ☐**Civil Union** - (If you are currently in a same sex marriage recognized by the State of Delaware or validly formed in another jurisdiction or Civil Union (please check one of these boxes)

☐**Not married** – (If not married, has an acknowledgment of paternity been completed for this child? That is, have you and the biological father signed a Delaware Acknowledgment of Paternity form in which the biological father accepted legal responsibility for the child? If you are not married, and an acknowledgment of paternity has not been completed, information about the biological father cannot be included on the birth certificate. Information about the procedures for adding the biological father information to the birth certificate after it has been filed can be obtained from the State Vital Statistics Office.

☐Yes, an Acknowledgement of Paternity has been completed [Please go to Question 16]

☐No, an Acknowledgement of Paternity has not been completed. The mother and the biological father:

☐I would like to talk to someone about completing an acknowledgment of paternity affidavit.

☐I would not like to talk to someone about completing the acknowledgment of paternity affidavit. [Please go to question 23]

**INFORMATION ON FATHER**

16. **What is the current legal name of your baby's father?**

_____ _____ _____ _____

First Middle Last Suffix (Jr., III, etc.)

17. **What is the father's date of birth?** (Example: March 4, 1976)

_____ _____ _____

Month Day Year

18. **In what State, U.S. territory, or foreign country was the father born?** Please specify one of the following:

State _____

*or*

U.S. Territory, i.e., Puerto Rico, U.S. Virgin Islands, Guam, American Samoa or Northern Marinas _____

*Or* foreign country _____

19. **What is the father's Social Security Number?** If you are not married, or if a Paternity Acknowledgment has not been completed, leave this item blank.

| | | | ---- | | | ---- | | | | |
|---|---|---|---|---|---|---|---|---|---|---|

**Patient Last Name:** _____ **DOB:** _____

**First** **Middle** **Due Date:**

| **Father's Employment Information** ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Other:_____ | |
|---|---|
| **Father's Employer Name & Occupation** | |

20. **What is the highest level of schooling that the father will have completed at the time of delivery**? (Check the box that best describes his education. If he is currently enrolled, check the box that indicated the previous grade or highest degree received.)

- ☐ 8th grade or less
- ☐ 9th – 12th grade, no diploma
- ☐ High school graduate or GED completed
- ☐ Some college credit, but no degree
- ☐ Associate degree (e.g. AA, AS)
- ☐ Bachelor's degree (e.g. BA, AB, BS)
- ☐ Master's degree (e.g. MA, MS, MEng, Med, MSW, MBA)
- ☐ Doctorate (e.g. PhD, EdD) or Professional degree (e.g. MD, DDS, DVM, LLB, JD)

21. **Is the father Spanish/Hispanic/Latino?** If not Spanish/Hispanic/Latino, check the "No" box. If Spanish/Spanish/Hispanic/Latino, check the appropriate box

- ☐ No, not Spanish/Hispanic/Latin
- ☐ Yes, Mexican, Mexican American, Chicana
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, other Spanish/Hispanic/Latina (e.g. Spaniard, Salvadoran, Dominican, Colombian) (Specify)_____

22. **What is the father's race?** Please check one or more races to indicate what he considers himself to be.

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native (name of enrolled or principal tribe) _____
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian (specify) _____
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander (specify) _____
- ☐ Other (specify) _____

**Your Prenatal History (Woman Giving Birth to this Child)**

23. **Date of first prenatal care visit.** Prenatal care begins when a physician or other health professional first examines and/or counsels the pregnant woman as part of an ongoing program of care for the pregnancy:

__ __ - __ __ - __ __ __ __
M M D D Y Y Y Y

24. **Date last normal menses began**. (Med 1/6)

__ __ - __ __ - __ __ __ __
M M D D Y Y Y Y

25. **Total number of previous live births now living**. (Do not include this child. For multiple deliveries, do not include the 1st born in the set if completing this worksheet for that child):

_____ ☐ None
Number

26. **Date of last live birth**.

__ __ - __ __ - __ __ __ __
M M D D Y Y Y Y

**Patient Last Name:** _____ **DOB:** _____

**First** **Middle** **Due Date:**

27. **Total number of previous live births now dead**.

_____ ☐ None
Number

28. **Total number of miscarriages or abortions**.

_____ ☐ None
Number

29. **Date of last other pregnancy outcome**. (Date when last pregnancy which did not result in a live birth ended):

__ __ - __ __ - __ __ __ __
M M D D Y Y Y Y

30. **What *will be* your newborn's race**? (Please check one or more races to indicate which will best represent your newborn's race.)

☐ White ☐ Black or African American ☐ American Indian or Alaska Native
☐ Asian ☐ Native Hawaiian / other Pacific Islander ☐ Other Race ☐ Declined

31. **What *will be* your newborn's ethnicity?**

☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Declined

| **Primary Insurance: ☐ Check this box if you will be adding newborn(s) to your Primary Insurance** | | | |
|---|---|---|---|
| Insurance Company: | | Policy number: | |
| Group number: | | Insurance phone number: | |
| Subscriber: | | Subscriber's date of birth: | |
| Relationship to patient: | ☐ Self ☐ Spouse ☐ Parent ☐ Other | Subscriber's social security number: | |
| Subscriber's employment status: | ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Other:_____ | | |
| Employer name, City and State | | | |
| Employer's Phone: | ( ) | | |
| **Secondary Insurance: ☐ Check this box if you will be adding newborn(s) to your Secondary Insurance** | | | |
| Insurance Company: | | Policy number: | |
| Group number: | | Insurance phone number: | |
| Subscriber: | | Subscriber's date of birth: | |
| Relationship to patient: | ☐ Self ☐ Spouse ☐ Parent ☐ Other | Subscriber's social security number: | |
| Subscriber's employment status: | ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Other:_____ | | |
| Employer name, City and State | | | |
| Employer's phone: | ( ) | | |
| **If Newborn will not be added to your Primary or Secondary insurance, do you wish to apply for Mediciad? Yes ☐ or No ☐** | | | |
| **Contacts –These individuals may be contacted in case of an emergency.** | | | |
| Contact #1 Name | | Relationship: | |
| Phone # | Home - ( ) | Cell – ( ) | |
| | | | |
| Contact #2 Name | | Relationship: | |
| Phone # | Home - ( ) | Cell – ( ) | |