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

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

CHRISTIANA CARE HEALTH SYSTEM

OB Physician Practice:
Primary Care Doctor:
Date:

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. This document will be used by your child throughout his/her life. Delaware law provides protection against the unauthorized release of identifying information from the birth certificate to ensure the confidentiality of the parents and their 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.

It is very important that you provide complete and accurate information to all of the questions. In addition to the birth certificate 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, race and smoking will be used for studies but will not appear on copies of the birth certificate issued to you or your child.

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

1. **What is your current legal name?** (Mother/2)

_____ _____ _____ _____
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?** (Mother/4)

_____ _____ _____
Month Day Year

4. **In what State, U.S. territory, or foreign country were you born?** (Mother/5)

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? _____

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

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* _____

6. **Is this household inside city limits** (inside the incorporated limits of the city, town, or location where you live)? (Mother/6)

CHECK ONE: ☐ Yes ☐ No ☐ Don't Know

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

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

7. **What is your mailing address?** (Mother/8)

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* _____

8. **What is your Social Security Number?** (Mother/9)

			----			----				

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)? (Mother/10)

- ☐ 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**? (Mother Dem/12)

☐ 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. (Mother Dem/13)

- ☐ 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.) (Mother Dem/14)

- ☐ 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. **What is your PREDOMINANT race?** (Please check ONLY one to indicate which best represents your race.) (Mother Dem/15)

- ☐ 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) _____

14. **Do you want a Social Security Number issued for your baby?** (Mother Dem/16)

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

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

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

15. 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 _____

16. 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. (Mother Dem/17)

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 17]

☐ Separated – [Read message above and Please go to question 17]

☐ 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 - (If you are currently in a same sex marriage recognized by the State of Delaware or validly formed in another jurisdiction please check this box).*(*A separate worksheet will be provided for completion.)*

☐ Civil Union - (If you are currently in a Civil Union recognized by the State of Delaware or validly formed in another jurisdiction please check this box) *(*A separate worksheet will be provided for completion.)*

☐ 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 17]
- ☐ 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 25]

INFORMATION ON FATHER

17. **What is the current legal name of your baby's father?** (Father/18)

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

18. **What is the father's date of birth?** (Example: March 4, 1976) (Father/19)

_____ _____ _____
Month Day Year

19. **In what State, U.S. territory, or foreign country was the father born?** Please specify one of the following: (Father/20)

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

20. **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. (Father/21)

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

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

21. **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.) (Father Dem/22)

- ☐ 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)

22. **Is the father Spanish/Hispanic/Latino?** If not Spanish/Hispanic/Latino, check the "No" box. If Spanish/Spanish/Hispanic/Latino, check the appropriate box. (Father Dem/23)

- ☐ 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)_____

23. **What is the father's race?** Please check one or more races to indicate what he considers himself to be. (Father Dem/24)

- ☐ 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) _____

24. **What is the father's PREDOMINANT race?** (Please check ONLY the one that indicates which best represents his race. (Father Dem/25)

- ☐ 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)

25. **What is your height?** (Med Tab 2/26)

_____feet _____inches

26. **How many cigarettes or packs of cigarettes did you smoke on an average day during each of the following time periods?** If you NEVER smoked, enter zero for each time period. (Med Tab 2/27)

	# of cigarettes	OR	# of packs
Three months before pregnancy	_____	OR	_____
First three months of pregnancy	_____	OR	_____
Second three months of pregnancy	_____	OR	_____
Last three months of pregnancy	_____	OR	_____

27. ***Pre*-pregnancy weight?** (Mother Dem/11.) _____ Lbs.

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

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

28. **Date of first prenatal care visit.** (Med 1/6) 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

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

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

30. **Total number of previous live births now living**. (Med 1/9) (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

31. **Date of last live birth**. (Med 1/9)

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

32. **Total number of previous live births now dead**. (Med 1/9)

_____ ☐ None
Number

33. **Total number of miscarriages or abortions**. (Med 1/9)

_____ ☐ None
Number

34. **Date of last other pregnancy outcome**. (Med 1/9) (Date when last pregnancy which did not result in a live birth ended):

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

35. **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

36. **What *will be* your newborn's PREDOMINANT race?** (Please check ONLY one 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

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

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

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

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

Guarantor – This person is the one who is **financially responsible** for the bill for this pregnancy. The Guarantor may not be an insurance carrier; it must be an individual who will take responsibility for the payments if an insurance company denies the claim.			
Name of guarantor:		Relationship:	☐ Self ☐ Spouse ☐ Parent ☐ Other
Address of guarantor:			
Home phone:	( )	Work/Cell phone:	( )
Guarantor's social security number:			
Guarantor's employment status: ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Other:_____			
Guarantor's employer name:			
Guarantor's employer address:			
Employment Information			
Patient's employment status: ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Other:_____			
Patient's employer name & Occupation:			
Patient's employer address:			
Father of baby's employment status: ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Other:_____			
Father of baby's employer name & Occupation:			
Father of baby's employer address:			
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:			
Employer's phone:	( )		
Employer's address:			
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:			
Employer's phone:	( )		
Employer's address:			
Religious Preference:			
Contacts –These individuals may be contacted in case of an emergency.			
Contact #1			
Name		Relationship:	
Address:			
Phone #	Home - ( )	Cell – ( )	
Contact #2			
Name		Relationship:	
Address:			
Phone #	Home - ( )	Cell – ( )	