CHILDPlus
PEDIATRIC HEALTH & WELLNESS

PRENATAL REGISTRATION

Welcome to our office! We are committed to providing the best, most comprehensive care possible for you and your new baby. We encourage you to ask questions regarding your child's health care. PLEASE PRINT the following information to assist us in treating your child.

Date ____ / ____ / _____

If known:

Baby's Name _____
First Middle Last

Sex _____ Term _____ Due Date ____ / ____ / ____

Mother's Name _____
First Middle Last

Age _____ Date of Birth ____ / ____ / ____

Home Address _____ City _____ State ____ Zip _____

Home Phone (_____) _____Cell Phone (_____) _____Email _____

Employer _____ Work Number (_____) _____

☐ Single ☐ Divorced ☐ Separated ☐Married to _____
Name Relationship to Patient

Father's Name _____
First Middle Last

Age _____ Date of Birth ____ / ____ / ____

Home Address _____ City _____ State ____ Zip _____

Home Phone (_____) _____Cell Phone (_____) _____Email _____

Employer _____ Work Number (_____) _____

☐ Single ☐ Divorced ☐ Separated ☐ Married to _____
Name Relationship to Patient

I certify that all information contained in this form is true and correct to the best of my knowledge. Child Plus Pediatrics has my permission to examine and administer treatment as deemed necessary to me and my unborn child. Co-pays, deductibles, and all co-insurance payments will be expected at time of service.

Signature: _____ Date: _____*

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604 E. Bailey Boswell, Suite 140, Saginaw TX 76131
Phone 817-484-6610 Fax 817-570-0181

PRENATAL MEDICAL HISTORY

Current Pregnancy

During this pregnancy have you:

Smoked tobacco ☐ No ☐ Yes, how much? _____

Drank alcohol ☐ No ☐ Yes, how much? _____

Taken prescribed drugs ☐ No ☐ Yes, which drugs/dose? _____

Taken illegal drugs ☐ No ☐ Yes, which drugs? _____

With this pregnancy have you been diagnosed with any of the following:

☐ Thyroid Disease	☐ High Blood Pressure	☐ Hepatitis
☐ Fifth's Disease	☐ Bleeding Disorder	☐ Rubella
☐ Diabetes	☐ Sickle Cell Disease	☐ Toxoplasmosis
☐ Epilepsy	☐ Herpes	☐ Lupus
☐ Asthma	☐ CMV (Cytomegalovirus)	☐ Other _____

Past Pregnancies

Number of previous pregnancies _____ Number of living children _____

Have any of your previous children had any of the following:

Delivered Pre-maturely ☐ No ☐ Yes, explain _____

Newborn Jaundice ☐ No ☐ Yes, explain _____

SIDS ☐ No ☐ Yes, explain _____

Serious Infection ☐ No ☐ Yes, explain _____

Heart Disease ☐ No ☐ Yes, explain _____

With any past pregnancy have you been diagnosed with any of the following:

☐ Thyroid Disease	☐ High Blood Pressure	☐ Hepatitis
☐ Fifth's Disease	☐ Bleeding Disorder	☐ Rubella
☐ Diabetes	☐ Sickle Cell Disease	☐ Toxoplasmosis
☐ Epilepsy	☐ Herpes	☐ Lupus
☐ Asthma	☐ CMV (Cytomegalovirus)	☐ Other _____

Previous pregnancy problems _____

_____

Family History

Do any family members have any of the following problems:

☐ Diabetes ☐ Allergies ☐ Convulsions ☐ Heart Disease ☐ TB ☐ Cancer ☐ Auto Immune Deficiency

Baby's Mother

Drug allergies ☐ No ☐ Yes, to what? _____

Baby's Father

☐ Living ☐ Deceased Current Age _____ General Health ☐ Good ☐ Average ☐ Other

Health problems? _____

Baby's Siblings

Sibling ☐ Living ☐ Deceased Current Age(s) _____General Health ☐ Good ☐ Average ☐ Other

☐ Male ☐ Female Lives with Patient ☐ No ☐ Yes ☐ Half-sibling ☐ Step-sibling

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Name(s): ______________________________

Sibling ☐ Living ☐ Deceased Current Age ______ General Health ☐ Good ☐ Average ☐ Other

☐ Male ☐ Female Lives with Patient ☐ No ☐ Yes ☐ Half-sibling ☐ Step-sibling

Name: ______________________________

Sibling ☐ Living ☐ Deceased Current Age ______ General Health ☐ Good ☐ Average ☐ Other

☐ Male ☐ Female Lives with Patient ☐ No ☐ Yes ☐ Half-sibling ☐ Step-sibling

Name: ______________________________

Sibling ☐ Living ☐ Deceased Current Age ______ General Health ☐ Good ☐ Average ☐ Other

☐ Male ☐ Female Lives with Patient ☐ No ☐ Yes ☐ Half-sibling ☐ Step-sibling

Name: ______________________________

Social History

How long has your family lived in this area? _________ Where did you move from? _________________

Who will have legal custody of baby? ______________________________

Name Relationship to baby

Please list the name and relationship of all individuals who will live with baby.

______________________________ ______________________________
Name Relationship Name Relationship

______________________________ ______________________________
Name Relationship Name Relationship

______________________________ ______________________________
Name Relationship Name Relationship

______________________________ ______________________________
Name Relationship Name Relationship

______________________________ ______________________________
Name Relationship Name Relationship

______________________________ ______________________________
Name Relationship Name Relationship

Does anyone who will live with baby use any of the following?

Tobacco ☐ No ☐ Yes, who ___________ Alcohol ☐ No ☐ Yes, who ___________

Other Drugs ☐ No ☐ Yes, who ___________

Do you have any special comments or concerns about your pregnancy or baby?

____

____

How did you find out about Dr. Davis and Child Plus Pediatrics?

Marketing Activities		*Please be as descriptive as possible as it track our marketing efforts*
Personal Referral		Name please so we can thank them
Practice Website		Yes
Referral from School		Which school and by whom
Advertising Banner		(The location if possible)
Magazine		Which Magazine or Paper

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