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NEW MOM INFORMATION

Date:_____ ___ John Rhodes M.D. ___Michael Marzullo M.D. ___Brian L. Adams M.D.

Infant's Last Name: _____Due Date:_____

INSURANCE & ID #: _____Group #: _____

Subscriber Name: _____ Relationship:_____ DOB:_____SOC #_____

Will the infant's last name change at birth, **if yes**, new name: _____

Will infant reside in same household with natural parent(s): ___mom ___dad ___both

Obstetrician: _____ Hospital:_____

Mother's Name: _____(last) _____(first)

Mother's Date of Birth: _____ Mother's Phone:_____

Father's Name: _____(last)_____(first)

Father's Date of Birth: _____ Father's Phone:_____

Mother's Medical History:

Any special problems with this pregnancy:

_____

_____

Blood type/RH: Mother_____ Father: _____

(Answer yes or no)

Fever:____ High Blood Pressure:____ Rashes:___ Diabetes:___ Infection:___ Bleeding:_____
Medication/drugs taken during pregnancy and when: _____

_____

X-rays or injury during pregnancy and when: _____

_____

Cesarean Section Planned? ___ Yes ___ NO; Reason:_____

Plans for Labor, Delivery, etc. Comment regarding childbirth classes, father's participation in labor and delivery, preferred anesthesia, etc.)

_____

_____

Plans for feeding: ___Breast ___Bottle ___Undecided

MALE INFANT: Circumcision: ___ YES ___NO ___Undecided

Previous Pregnancies: _____ including present; ____ # of Living children ____ Miscarriages

Year of Birth	Sex	Birth Weight	Special Problems	Pt. here/Name
_____	____	_____	_____	y/n_____
_____	____	_____	_____	y/n_____
_____	____	_____	_____	y/n_____

IMMUNIZATIONS: Do you have a problem immunizing your child? ____Yes ____No

ASSIGNMENT OF BENEFITS & AUTHORIZATION FOR INFORMATION RELEASE

1. **I hereby assign and authorize payment of Medicaid and other insurance benefits, otherwise payable to me, directly to Rhodes Pediatric Clinic (Dr. Rhodes and Dr. Marzullo) for office or hospital services, which are not paid by me at the time of service.**
2. **I understand that I am ultimately responsible for payment of any and all charges for treatment received and if the assigned claim is rejected, modified, or not paid within a reasonable time after it has been filed, it will be my responsibility to pay any unpaid charges in full.**
3. **I hereby authorize Rhodes Pediatric Clinic and its providers, to provide treatment for the patient listed above, and to release all information pertaining to office or hospital services rendered to me by said practice, including the diagnosis and treatment rendered to me by previous physicians, hospitals, or other medical facilities/personnel.**

Parent/Caregiver Signature: _____Date:_____