Baby Consult Questionnaire

Date_____

Mother's Name_____ DOB _____

Address _____

Phone # _____ Alt Phone # _____

Insurance _____ ID# _____

Group # _____ Ins. Phone # _____

Insurance Address _____

Guarantor's Name _____ DOB _____

Guarantor's Address _____ SSN _____

1. Who is your OB? _____
2. Is this your 1st baby? Y/N If no, any complication with other deliveries? Y/ N
3. Any problems with this pregnancy? Y/N _____
4. What is the sex of the baby? Male/Female/Surprise If male, plan circ? Y/N
5. When is your due date? _____
6. Are you planning a vaginal delivery or a C-Section? _____
7. Where are you delivering? _____
8. Are you planning to breast feed or formula? _____

9. Are you planning to use CDC recommended vaccine schedule? Y/N

10. Do you have any concerns regarding vaccines? Y/N _____

11. Are you opposed to seeing a mid-level provider once your baby gets older Y/N