TEXOMACARE

Date: _____

Chart Number: _____

Newborn Registration Information

Mom's Name: _____ Date of Birth: _____ Occupation: _____

Dad's Name: _____ Date of Birth: _____ Occupation: _____

Address: _____ Siblings: ☐ None _____
Street or P.O. Box — Name, Ages, Relationship

_____
City, State, Zip Code

_____

Contact Information: (Please check preferred method of phone contact.)

☐ **Home:** _____

☐ **Cell #1:** _____

☐ **Cell #2:** _____

☐ **Work:** _____

e-mail: _____

Other: _____

Are you having a ☐ **Boy** or ☐ **Girl?**

Have you picked out a **Name** yet? ☐ **No** ☐ **Yes** _____
Can you tell us?

Due Date? _____ **Obstetrician?** _____

Do you have any questions or concerns with this pregnancy? ☐ **No** ☐ **Yes** _____
Please list.

_____

Any problems with previous pregnancies? ☐ **No** ☐ **Yes** ☐ **N/A**

Any problems with previous children in the immediate period after their birth? ☐ **No** ☐ **Yes** ☐ **N/A**

Any medical conditions or diseases that occur in the family or parents? ☐ **No** ☐ **Yes**

Do you have any special needs or concerns for the pediatrician after the baby is born? ☐ **No** ☐ **Yes**

_____
Please list.

What are your plans for feeding? ☐ **Breastfeeding** ☐ **Bottle** ☐ **Both** ☐ **I don't know.**

Are you attending or plan to attend childbirth preparation classes? ☐ **Yes** ☐ **No**

TEXOMACARE

INSURANCE & BILLING INFORMATION

Patient's Name: _____ DOB: _____
☐ Male ☐ Female
Street Address: _____
Street City State Zip Code
Father's Name: _____
Home Address: _____
Street City State Zip Code
Employer: _____
Group Insurance: _____
Policy Number: _____ Group Number: _____
SSN: _____ Benefit Code: _____
Father's DOB: _____

(We need a copy of your most recent insurance card, and an address to mail claim.)

Mother's Name: _____
Home Address: _____
Street City State Zip Code
Employer: _____
Group Insurance: _____
Policy Number: _____ Group Number: _____
SSN: _____ Benefit Code: _____
Mother's DOB: _____

(We need a copy of your most recent insurance card, and an address to mail claim.)

ASSIGNMENT OF INSURANCE BENEFITS:
I hereby authorize direct payment of benefits to Dr. _____ for services rendered by him / her in person or under his / her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

_____
Responsible party (parent and / or guardian)

AUTHORIZATION TO RELEASE INFORMATION
I hereby authorize Dr. _____ to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

A photocopy of these assignments shall be valid as the original.

_____ _____
Responsible party (parent and / or guardian) Date