BABY CONSULTATION QUESTIONNAIRE

MOTHER'S NAME: DOB:

ADDRESS:

PHONE: ALT PHONE:

EMAIL ADDRESS:

INSURANCE NAME: PHONE:

GROUP #: ID #:

INSURANCE ADDRESS:

POLICY HOLDER'S INFORMATION:

NAME: DOB:

SSN#:

ADDRESS:

PREGNANCY HISTORY:

Due date: Delivering where:

Who is your OB/GYN?

Is this your 1st baby? ○ Yes ○ No How many pregnancies have you had?

Any complications with this pregnancy or previous pregnancies? ○ Yes ○ No

Describe:

Vaginal delivery or scheduled c-section?

What is the sex of the baby? ○ Male ○ Female If male, do you plan on circumcising him? ○ Yes ○ No

Breastfeeding or formula? _____

Do you plan on using CDC recommended vaccines? ○ Yes ○ No

Any concerns with CDC recommended vaccines? ○ Yes ○ No

If yes, explain _____

Are you opposed to seeing a mid-level provider once your baby gets older? ○ Yes ○ No

Please fill out the form and email to

newpt@gruenelakemedical.com