CARLOS ORTIZ MD PC
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All gathered information will be monitored in compliance with the HIPPA/ Privacy Rules (Newborn RV2006)

INFANT & MOTHER HEALTH INFORMATION

Child's Legal Name:	Date of Birth: _____/_____/_____
Home Address: _____ _____	
Primary Telephone #: (_____) _____-_____	
Mother's Legal Name:	Father's Legal Name:
What hospial was the baby born at?	Was it a vaginal or caesarean delivery?
Was the baby premature? Induced? Any complications? ICU?	
Who was the Mother's OB GYN?	Who was the Pediatrician who saw and discharged the infant from the hospital?
What were the dates that the baby remained in the hospital?	If it was more than 3 days, please explain why:
Did the baby receive the firstof the Hep B Vaccines in the hospital? Yes or No	What was the baby's birth weight and height? _____lbs _____oz _____inches long
Was the infant's hearing screening normal? Yes or No	

INFANT & MOTHER INSURANCE INFORMATION

Is the infant covered by the Mother's or Father's insurance?	What is the name of the insurance?
What is the SS# of the person providing the infant with insurance?	Was the insurance company notified of the birth of the infant? Yes or No
Will the baby continue with the same insurance after 30 days? Yes or No	Will the baby have a second insurance? If yes, which one? Yes or No *Which one?*_____

_____ _____/_____/_____

Signature of the person filling out this form **Today's Date**