

**PRENATAL INSURANCE INTERVIEW**

APPOINTMENT DATE \_\_\_\_\_ DUE DATE \_\_\_\_\_

PATIENT NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ SOCIAL SECURITY \_\_\_\_\_

SPOUSE DATE OF BIRTH \_\_\_\_\_ SPOUSE SOCIAL SECURITY \_\_\_\_\_

**PRIMARY INSURANCE COMPANY NAME** \_\_\_\_\_

PPO/HMO PLAN \_\_\_\_\_

PREFERRED HOSPITAL \_\_\_\_\_ PREFERRED LAB \_\_\_\_\_

INSURANCE CLAIMS ADDRESS \_\_\_\_\_

\_\_\_\_\_

PHONE \_\_\_\_\_

INSURED EMPLOYER \_\_\_\_\_ PHONE \_\_\_\_\_

INSURED NAME \_\_\_\_\_ INSURED BIRTHDATE \_\_\_\_\_

ID# ON CARD \_\_\_\_\_ GROUP/POLICY # \_\_\_\_\_ EFFECTIVE DATE \_\_\_\_\_

RELATIONSHIP OF PATIENT TO INSURED \_\_\_\_\_

**SECONDARY INSURANCE COMPANY NAME** \_\_\_\_\_

PPO/HMO PLAN \_\_\_\_\_

PREFERRED HOSPITAL \_\_\_\_\_ PREFERRED LAB \_\_\_\_\_

INSURANCE CLAIMS ADDRESS \_\_\_\_\_

\_\_\_\_\_

PHONE \_\_\_\_\_

INSURED EMPLOYER \_\_\_\_\_ PHONE \_\_\_\_\_

INSURED NAME \_\_\_\_\_ INSURED BIRTHDATE \_\_\_\_\_

ID# ON CARD \_\_\_\_\_ GROUP/POLICY# \_\_\_\_\_ EFFECTIVE DATE \_\_\_\_\_

RELATIONSHIP OF PATIENT TO INSURED \_\_\_\_\_

**WE REQUIRE COPIES OF ALL INSURANCE CARDS MENTIONED ABOVE**

ADDITIONAL INFORMATION \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

INTERVIEWER \_\_\_\_\_

## OB QUESTIONNAIRE

Patient Name: \_\_\_\_\_

1. Have you ever had any of the following infections?
  - A. Chlamydia                      Yes   No
  - B. Condyloma                      Yes   No
  - C. Gonorrhea                      Yes   No
  - D. Hepatitis                      Yes   No
  - E. Herpes                      Yes   No
  - F. Syphilis                      Yes   No
  - G. Trichomonas                      Yes   No

If you have had a previous pregnancy, please answer the following questions

2. Were you ever treated for preterm labor?                      Yes   No  
If yes, how early did it start?                      \_\_\_\_\_ weeks gestation
3. Did you deliver before 36 weeks gestation?                      Yes   No
4. Did you have hypertension (High Blood Pressure)?                      Yes   No  
If yes, did you need bed rest?                      Yes   No                      or Medication?                      Yes   No
5. Was your labor induced?                      Yes   No  
If yes, at what week?                      \_\_\_\_\_                      Why?                      \_\_\_\_\_
6. Did you have diabetes?                      Yes   No  
If yes, were you on medication?                      Yes   No                      What?                      \_\_\_\_\_
7. Did you have Group B Strep?                      Yes   No
8. Did you have any bleeding problems?                      Yes   No
9. Have you ever had an ectopic pregnancy?                      Yes   No
10. Have you ever had any problems with the delivery of your placenta?                      Yes   No
11. Did you deliver by cesarean section?                      Yes   No
12. Have you had any other pregnancy complications?                      Yes   No