Alliance Pediatrics

12461 Timberland Blvd, Ste 309
4400 Heritage Trace Parkway Ste 208
Fort Worth, Texas 76244
Office: (817) 741-5437
Fax: (817) 431-5870

PRENATAL REGISTRATION

Welcome to our office! We are committed to providing the best, most comprehensive care possible for you and your new baby. We encourage you to ask questions regarding your child's health care. PLEASE PRINT the following information to assist us in treating your child.

Date ____ / ____ / _____

If known:
Baby's Name _____
First Middle Last

OB/GYN: _____ Sex: _____ Due Date ____ / ____ / ____

What hospital do you plan to deliver at?_____

Do you plan to breast or bottle feed?_____

If you breastfeed are you interested in finding out more about lactation services in our office? ☐No ☐Yes

Do you have any vaccine concerns?_____

Mother's Name _____
First Middle Last

Date of Birth ____ / ____ / ____

Home Address _____ City _____ State ____ Zip _____

Home Phone (_____) _____ Cell Phone (_____) _____

☐ Single ☐ Divorced ☐ Separated ☐Married to _____
Name Relationship to Patient

Mother's Email _____@_____

Father's Name _____
First Middle Last

Date of Birth ____ / ____ / ____

Home Address _____ City _____ State ____ Zip _____

Home Phone (_____) _____ Cell Phone (_____) _____

☐ Single ☐ Divorced ☐ Separated ☐ Married to _____
Name Relationship to Patient

Father's Email _____@_____

How did you find out about Alliance Pediatrics?

☐ Friend ☐ Drive-by ☐ OB/GYN ☐ Website ☐ Other_____

Current Insurance Carrier:_____

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Current Pregnancy

During this pregnancy have you:

Smoked tobacco ☐ No ☐ Yes, how much? _____

Drank alcohol ☐ No ☐ Yes, how much? _____

Taken prescribed drugs ☐ No ☐ Yes, which drugs? _____

Taken illegal drugs ☐ No ☐ Yes, which drugs? _____

With this pregnancy have you been diagnosed with any of the following:

☐ Thyroid Disease ☐ High Blood Pressure ☐ Hepatitis
☐ Fifth's Disease ☐ Bleeding Disorder ☐ Rubella
☐ Diabetes ☐ Sickle Cell Disease ☐ Toxoplasmosis
☐ Epilepsy ☐ Herpes ☐ Lupus
☐ Asthma ☐ CMV (Cytomegalovirus) ☐ Other _____

Past Pregnancies

Number of previous pregnancies _____ Number of living children _____

Have any of your previous children had any of the following:

Delivered Pre-maturely ☐ No ☐ Yes, explain _____

Newborn Jaundice ☐ No ☐ Yes, explain _____

SIDS ☐ No ☐ Yes, explain _____

Serious Infection ☐ No ☐ Yes, explain _____

Heart Disease ☐ No ☐ Yes, explain _____

With any past pregnancy have you been diagnosed with any of the following:

☐ Thyroid Disease ☐ High Blood Pressure ☐ Hepatitis
☐ Fifth's Disease ☐ Bleeding Disorder ☐ Rubella
☐ Diabetes ☐ Sickle Cell Disease ☐ Toxoplasmosis
☐ Epilepsy ☐ Herpes ☐ Lupus
☐ Asthma ☐ CMV (Cytomegalovirus) ☐ Other _____

Previous pregnancy problems _____

_____

Family History

Do any family members have any of the following problems:

☐ Diabetes ☐ Allergies ☐ Convulsions ☐ Heart Disease ☐ TB ☐ Cancer ☐ Auto Immune Deficiency

Baby's Mother

Drug allergies ☐ No ☐ Yes, to what? _____

Baby's Father

☐ Living ☐ Deceased Current Age _____ General Health ☐ Good ☐ Average ☐ Other

Health problems? _____

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PRENATAL REGISTRATION

Baby's Siblings

Sibling ☐ Living ☐ Deceased Current Age ______ General Health ☐ Good ☐ Average ☐ Other
☐ Male ☐ Female Lives with Patient ☐ No ☐ Yes ☐ Half-sibling ☐ Step-sibling
Name: ____

Sibling ☐ Living ☐ Deceased Current Age ______ General Health ☐ Good ☐ Average ☐ Other
☐ Male ☐ Female Lives with Patient ☐ No ☐ Yes ☐ Half-sibling ☐ Step-sibling
Name: ____

Sibling ☐ Living ☐ Deceased Current Age ______ General Health ☐ Good ☐ Average ☐ Other
☐ Male ☐ Female Lives with Patient ☐ No ☐ Yes ☐ Half-sibling ☐ Step-sibling
Name: ____

Sibling ☐ Living ☐ Deceased Current Age ______ General Health ☐ Good ☐ Average ☐ Other
☐ Male ☐ Female Lives with Patient ☐ No ☐ Yes ☐ Half-sibling ☐ Step-sibling
Name: ____

Social History

How long has your family lived in this area? _________ Where did you move from? _________________

Who will have legal custody of baby? ____
Name Relationship to baby

Please list the name and relationship of all individuals who will live with baby.

Name	Relationship	Name	Relationship
Name	Relationship	Name	Relationship
Name	Relationship	Name	Relationship
Name	Relationship	Name	Relationship
Name	Relationship	Name	Relationship
Name	Relationship	Name	Relationship

Does anyone who will live with baby use any of the following?

Tobacco ☐ No ☐ Yes, who ___________ Alcohol ☐ No ☐ Yes, who ___________
Other Drugs ☐ No ☐ Yes, who ___________

Do you have any special comments or concerns about your pregnancy or baby?

____

____

____

Name of Provider you are Visiting:____

SUBMIT

Patient Name: ____