Notification of Pregnancy

ONE MEMBER PER FORM

silversummit healthplan

This form is confidential. If you have any problems or questions, please call 1-844-366-2880 (TTY/TTD: 1-844-804-6086). This form is also available online.

*Required Field

*Are You Pregnant? ☐ Yes ☐ No * If you are pregnant, please continue to answer all the questions.

Return the form in the envelope provided. When your answers are received, a gift will be mailed to you!

We may call you if we find that you are at risk for problems with your pregnancy.

*Member ID #: Today's Date MMDDYYYY:

Your First Name:

Your Last Name:

Your Birth Date MMDDYYYY:

Mailing Address:

City: State: Zip Code:

Home Phone: Cell Phone:

Would you like to receive text messages about pregnancy and newborn care? ☐ Yes ☐ No

If you do not have an unlimited texting plan, message and data rates may apply. Text STOP to unsubscribe. Please note, texting is not secure and may be seen by others.

Email Address:

Your OB Provider's Name:

Your Due Date MMDDYYYY:

Primary insurance (for mom or baby) other than Medicaid? ☐ Yes ☐ No

Race/Ethnicity (select all that apply): ☐ White ☐ Black/African American ☐ Hispanic/latina

☐ American Indian/Native American ☐ Asian ☐ Hawaiian/Pacific Islander

☐ Other If other ethnicity, please specify:

Preferred Language (if other than English):

Planning to breastfeed? ☐ Yes ☐ No If no, what is the reason?

Pediatrician chosen? ☐ Yes ☐ No Pediatrician Name:

Number of Full Term Deliveries: Number of Miscarriages:

Number of Preterm Deliveries: Number of Stillbirths:

Height: Pre-Pregnancy Weight:

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Name: Last, First:

Do you have any of the following? ☐ Yes ☐ No If yes, mark all that apply.

Your Medical History

Previous preterm delivery (<37 weeks or a delivery more than three weeks early)? ☐ Yes ☐ No

Recent delivery within past 12 months? ☐ Yes ☐ No

Was delivery within past 6 months? ☐ Yes ☐ No

Previous C-Section? ☐ Yes ☐ No

Diabetes (Prior to Pregnancy)? ☐ Yes ☐ No

Sickle Cell? ☐ Yes ☐ No

Asthma? ☐ Yes ☐ No

If yes, are asthma symptoms worse during pregnancy? ☐ Yes ☐ No

High blood pressure (prior to pregnancy)? ☐ Yes ☐ No

Previous neonatal death or stillbirth? ☐ Yes ☐ No

HIV Positive? ☐ Yes ☐ No HIV Negative? ☐ Yes ☐ No

Testing refused? ☐ Yes ☐ No AIDS? ☐ Yes ☐ No

Thyroid Problems? ☐ Yes ☐ No

Seizure Disorder? ☐ Yes ☐ No

Seizure within the last 6 months? ☐ Yes ☐ No

Previous alcohol or drug abuse? ☐ Yes ☐ No

Do you have enough food? ☐ Yes ☐ No

Do you lack reliable phone access? ☐ Yes ☐ No

Are you enrolled in WIC? ☐ Yes ☐ No

Current Pregnancy History

Preterm labor this pregnancy? ☐ Yes ☐ No

Current gestational diabetes? ☐ Yes ☐ No

Current twins? ☐ Yes ☐ No

Current triplets? ☐ Yes ☐ No

Currently having severe morning sickness? ☐ Yes ☐ No

Current mental health concerns? ☐ Yes ☐ No

List:

Current STD? ☐ Yes ☐ No

List:

Current tobacco use? ☐ Yes ☐ No

Amount:

If yes, are you interested in quitting? ☐ Yes ☐ No

Current alcohol use? ☐ Yes ☐ No

Amount:

Current street drug use? ☐ Yes ☐ No

Taking any prescription drugs (other than prenatal viamins)? ☐ Yes ☐ No

List:

Any hospital stays this pregnancy? ☐ Yes ☐ No

Are you homeless or living in a shelter? ☐ Yes ☐ No

Do you have problems getting to your doctor visits? ☐ Yes ☐ No

Do you feel unsafe in your home? ☐ Yes ☐ No

Please list any other social needs you may have:

Pleae list anything else you would like to tell us about your health:

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