Mother's Name:	Mother's Med. Rec. Number:

New Birth Registration

Parents – Mother

Mother's First Name:	Mother's Middle Name:
Mother's Current Last Name :	Last Name on Mother's Birth Certificate:
Social Security Number: – –	Mother's Date of Birth: *(MM/DD/YYYY)* / /
Infant's First Name:	Infant's Middle Name:
Infant's Last Name:	Infant's Name Suffix *(e.g. Jr., 2nd, III)*:

Infant

Sex: ☐ Male ☐ Female ☐ Undetermined	Plurality:	Birth Order:	Medical Record No.:
Date of Birth: *(MM/DD/YYYY)* / /	Time of Birth: *(HH:MM)* :	☐ am ☐ pm ☐ military (24-hour time)	

Parents – Infant

Was child born in this facility? ☐ Yes ☐ No If child was **not** born in this facility, please answer the following questions:

In what type of place was the infant born?

☐ Freestanding Birth Center (regulated by DOH)
☐ Home (intended)
☐ Home (unintended)
☐ Home (unknown intent)
☐ Clinic / Doctor's Office (not regulated by DOH)
☐ Other

If New York State Birthing Center, enter its name:

In what county was the child born?

Parents – Birthplace

Institution

Site of Birth, If **Other** Type of Place:

Street Address – if other than Hospital / Birthing Center:

If place of infant's birth was other than Hospital or Birthing Center:

City, town or village where birth occurred:

Zip / Postal Code:

Infant's Pediatrician/Family Practitioner: **NBS**

Attendant

Attendant's Information:

License Number: Name: *First* *Middle* *Last*

Title: *(Select one)*

☐ Medical Doctor ☐ Doctor of Osteopathy ☐ Licensed Midwife (CNM) ☐ Licensed Midwife (CM) ☐ Other

Certifier

Certifier's Information:

☐ Check here if the Certifier is the same as the Attendant *(otherwise enter information below)*

License Number: Name: *First* *Middle* *Last*

Title: *(Select one)*

☐ Medical Doctor ☐ Doctor of Osteopathy ☐ Licensed Midwife (CNM) ☐ Licensed Midwife (CM) ☐ Other

Parents – Payor

Primary Payor for this Delivery:

Select one:

☐ Medicaid / Family Health Plus
☐ Private Insurance
☐ Indian Health Service
☐ CHAMPUS / TRICARE
☐ Other Government / Child Health Plus B
☐ Other
☐ Self-pay

If Medicaid is not the primary payor, is it a secondary payor for this delivery? ☐ Yes ☐ No

Is the mother enrolled in an HMO or other managed care plan? ☐ Yes ☐ No **QI**

Mother's Name: *First*	*Middle*	*Last*	Mother's Med. Rec. Number:
Father / Second Parent Name: *First*	*Middle*	*Last*	*Suffix*
Infant's Name: *First*	*Middle*	*Last*	*Suffix*	Date of Birth

To the hospital:

1. Obtain the parent(s) signature(s).
2. File the original Release Form in the mother's hospital record.
   Note: It is not necessary to file the remainder of the Work Booklet.
3. Provide a copy to the parent(s).
4. Do **not** send copies to the New York State Department of Health or to any Social Security office, unless specifically requested by such agency.

To the parent(s):

1. Please read the following notice about the collection and use of Social Security Numbers on your child's birth certificate.
2. Please check "Yes" or "No" to indicate if you wish to participate in the Social Security Administration's Enumeration at Birth program.

NOTICE REGARDING COLLECTION OF PARENTS' SOCIAL SECURITY NUMBERS: The collection of parents' Social Security Numbers on the New York State Certificate of Live Birth is mandatory. They are required by Public Health Law Section 4132(1) and may be used for child support enforcement, public health related purposes, when requested by State, federal and municipal governments for official purposes, when required by Public Health Law Section 4173 or 4174, and when otherwise required or authorized by law.

Social Security Release

The Social Security Administration offers the parents of newborns an opportunity to apply for a Social Security Number for their child through the birth certificate registration process. This is referred to by the Social Security Administration as Enumeration at Birth (EAB). If you participate in the EAB, the New York State Department of Health will forward to the Social Security Administration information from your child's birth certificate. Please note that the Social Security Administration will not process your EAB request unless, the birth certificate includes your child's full name. If you participate in the EAB, disclosure of parents' Social Security Numbers is mandated by 42 U.S.C. 405(c)(2). The Social Security Number(s) will be used by the Internal Revenue Service (IRS) solely for the purpose of determining Earned Income Tax Credit compliance. If you wish to participate in the Social Security Administration EAB program check "Yes" below.

May the Social Security Administration be furnished with information from this form to issue your child a social security number?

Yes ☐

No ☐

Mother's Signature ▶ _____ **Date** _____

Father's or Second Parent's Signature ▶ _____ **Date** _____

Either parent's signature applies to the above release.
If neither box is checked for the release, a 'No' response will be assumed.

Hospital Name:	
Signature of Hospital Representative: ▶	Date:

Mother's Name:	Mother's Med. Rec. Number:

Mother

Medical Record Number:

Parents

Mother's Demographics

Mother's Education: *(select one)*

- ☐ 8th grade or less
- ☐ 9th – 12th grade; no diploma
- ☐ High school graduate; or GED
- ☐ Some college credit, but no degree
- ☐ Associate's degree
- ☐ Bachelor's degree
- ☐ Master's degree
- ☐ Doctorate degree

City of Birth:	State/Terr./Province of Birth:	Country of Birth, if not USA:

Hispanic Origin:

Select all that apply

- ☐ No, not Spanish/Hispanic/Latina
- ☐ Yes, Cuban
- ☐ Yes, Mexican, Mexican American, Chicana
- ☐ Yes, Other Spanish/Hispanic/Latina
  Specify:
- ☐ Yes, Puerto Rican

Mother's Demographics

Race:

Select all that apply

- ☐ White/Caucasian
- ☐ Chinese
- ☐ Korean
- ☐ Guamanian or Chamorro
- ☐ American Indian or Alaska Native **Tribe:**
- ☐ Other Asian **Specify:**
- ☐ Other Pacific Islander **Specify:**
- ☐ Other **Specify:**
- ☐ Black or African American
- ☐ Filipino
- ☐ Vietnamese
- ☐ Samoan
- ☐ Asian Indian
- ☐ Japanese
- ☐ Native Hawaiian

Mother's Residence

Residence Address

Street Address:

State/Terr./Province:	County:	City, Town or Village:

Zip/Postal Code:	Mother's Country of Residence, if not USA:	U.S./Canadian Phone Number: ( ) –

Mother's Mailing Address

Mailing Address – Most Recent

☐ Check here if the mailing address is the same as the residence address *(otherwise enter information below)*

Mailing Address:

City, Town or Village:	State/Terr./Province:	Country, if not USA:	Zip/Postal Code:

Employment

Employment History

Employed while Pregnant: ☐Yes ☐No	Current / Most Recent Occupation:	Kind of Business / Industry:

Name of Company or Firm:	Address:

City:	State/Territory/Province:	Zip / Postal Code:

Mother's Name:	Mother's Med. Rec. Number:

Father or Second Parent

Will the mother and father be executing an Acknowledgement of Paternity? ☐ Yes ☐ No ☐ Not required

What type of certificate is required? ☐ Mother / Father ☐ Mother / Mother

Parents

Father's or Second Parent's Demographics

Parent's First Name:	Parent's Middle Name:
Parent's Current Last Name:	Last Name on Parent's Birth Certificate:
Parent's Name Suffix *(e.g. Jr., 2nd, III)*:	Social Security Number: – –

Demographics

Parent's Date of Birth: *(MM/DD/YYYY)*
/ /

Education: *(select one)*

- ☐ 8th grade or less
- ☐ 9th – 12th grade; no diploma
- ☐ High school graduate; or GED
- ☐ Some college credit, but no degree
- ☐ Associate's degree
- ☐ Bachelor's degree
- ☐ Master's degree
- ☐ Doctorate degree

City of Birth:	State/Terr./Province of Birth:	Country of Birth, if not USA:

Hispanic Origin:

Select all that apply

- ☐ No, not Spanish/Hispanic/Latino
- ☐ Yes, Cuban
- ☐ Yes, Mexican, Mexican American, Chicano
- ☐ Yes, Other Spanish/Hispanic/Latino — **Specify:**
- ☐ Yes, Puerto Rican

Race:

Select all that apply

- ☐ White/Caucasian
- ☐ Chinese
- ☐ Korean
- ☐ Guamanian or Chamorro
- ☐ American Indian or Alaska Native **Tribe:**
- ☐ Other Asian **Specify:**
- ☐ Other Pacific Islander **Specify:**
- ☐ Other **Specify:**
- ☐ Black or African American
- ☐ Filipino
- ☐ Vietnamese
- ☐ Samoan
- ☐ Asian Indian
- ☐ Japanese
- ☐ Native Hawaiian

Parent's Residence

Residence Address

☐ Check here if the parent's residence address is the same as the mother's address *(otherwise enter information below)*

Street Address:	
City, Town or Village:	State / Territory / Province:
Parent's Country of Residence, if not USA:	Zip / Postal Code:

Employment

Employment History

Current / Most Recent Occupation: Kind of Business / Industry:

Name of Company or Firm:	Address:	
City:	State / Territory / Province:	Zip / Postal Code:

Mother's Name:	Mother's Med. Rec. Number:

Interview/Records QI

Parents

Survey of Mother (in hospital)

Survey of Mother (in hospital)

Did you receive prenatal care? ☐ Yes ☐ No *(If 'Yes' please answer question 1. Otherwise skip to question 2.)*

1. During any of your prenatal care visits, did a doctor, nurse, or other health care worker talk with you about any of the things listed below?

	Yes	No
a. How smoking during pregnancy could affect your baby?	☐	☐
b. How drinking alcohol during your pregnancy could affect your baby?	☐	☐
c. How using illegal drugs could affect your baby?	☐	☐
d. How long to wait before having another baby?	☐	☐
e. Birth control methods to use after your pregnancy?	☐	☐
f. What to do if your labor starts early?	☐	☐
g. How to keep from getting HIV (the virus that causes AIDS)?	☐	☐
h. Physical abuse to women by their husbands or partners?	☐	☐

2. How many times per week during your current pregnancy did you exercise for 30 minutes or more, above your usual activities? — Times per week:

3. Did you have any problems with your gums at any time during pregnancy, for example, swollen or bleeding gums? ☐ Yes ☐ No

4. During your pregnancy, would you say that you were: *(select one)*
   ☐ Not depressed at all ☐ A little depressed
   ☐ Moderately depressed ☐ Very depressed
   ☐ Very depressed and had to get help

5. Thinking back to just before you were pregnant, how did you feel about becoming pregnant?
   ☐ You wanted to be pregnant sooner ☐ You wanted to be pregnant later
   ☐ You wanted to be pregnant then ☐ You didn't want to be pregnant then or at any time in the future

Chart Review (Prenatal and Medical)

Chart Review (Prenatal and Medical)

1a. Copy of prenatal record in chart?
   ☐ Yes, Full Record ☐ Yes, Prenatal Summary Only
   ☐ No

1b. Was formal risk assessment in prenatal chart?
   ☐ Yes, with Social Assessment ☐ Yes, without Social Assessment
   ☐ No

1c. Was MSAFP / triple screen test offered?
   ☐ Yes ☐ No
   ☐ No, Too Late

1d. Was MSAFP / triple screen test done?
   ☐ Yes ☐ No

2. How many times was the mother hospitalized during this pregnancy, not including hospitalization for delivery?

Admission & Discharge

Admission and Discharge Information

Mother

Admission Date for Delivery *(MM/DD/YYYY)*	Discharge Date *(MM/DD/YYYY)*
/ /	/ /

Infant

Discharge Date *(MM/DD/YYYY)* / /

☐ Discharged Home ☐ Infant Died at Birth Hospital
☐ Infant Still in Hospital ☐ Infant Discharged to Foster Care/Adoption
☐ Infant Transferred Out ☐ Unknown