Maternity Questionnaire

Please submit this form and all related correspondence to:

Service Address:
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Coral Gables, Fl 33134 USA

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USA Toll Free: + 1 (800) 222-3002
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PATIENT INFORMATION

MUST BE COMPLETED BY THE ATTENDING OBSTETRICIAN.

1. Name of Patient

2. Policy Holder Name

3. Policy ID Number

4. Patient's Birth Date
MM/DD/YYYY

5. Date of Last Menstrual Period
MM/DD/YYYY

6. Expected Date of Delivery
MM/DD/YYYY

7. Anticipated Type of Delivery (check one)
☐ Vaginal ☐ Cesarean Section

8. Please provide the number of: a) ☐ Pregnancies b) ☐ Vaginal Deliveries c) ☐ C-Sections d) ☐ Miscarriages/ Abortions

9. Has the patient experienced any of the following:

a) ☐ Premature births	If so, how many?
b) ☐ Complications during Pregnancy or Delivery	If so, how many?
c) ☐ Multiples Pregnancy	If so, how many?

d) In case of C-Section, miscarriage, complications or premature birth, please explain the cause:

10. Blood Type

Rh ☐ + ☐ -

11. History of Fertility/Infertility Treatments (Include all medications, surgical procedures, etc. for the past 3 years)

12. Is the patient in an In Vitro Fertilization Program? ☐ Yes ☐ No

13. Anticipated Amniocentesis or other testing to be performed (If tests are performed, results should be sent to Premier Health)

14. Has the patient had surgery of the reproductive organs?
☐ Yes ☐ No
If Yes, please explain

15. Has the patient had eclampsia, pre-eclampsia, placenta previa or ectopic pregnancy?
☐ Yes ☐ No
If Yes, please explain

16. Has the patient been diagnosed with any heart or circulatory disorder, diabetes, anemia, or other chronic disease?
☐ Yes ☐ No
If Yes, please explain

WEA

PATIENT INFORMATION CONTINUED

MUST BE COMPLETED BY THE ATTENDING OBSTETRICIAN.

17. Has the patient or a close relative had a child with congenital or hereditary disease?

☐ Yes ☐ No

If Yes, please explain

18. Does the patient have any other disorder not mentioned before?

☐ Yes ☐ No

If Yes, please explain

19. Is the patient taking any medication?

☐ Yes ☐ No

If Yes, please explain

PHYSICIAN INFORMATION

20. Name of the Attending Physician

21. Phone Number

22. Fax Number

23. Email

24. Skype

PHYSICIAN SIGNATURE

Signature

Date

MM/DD/YYYY

FRAUD WARNING

Any person, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, who submits an application or files a claim containing a false or deceptive statement, is guilty of insurance fraud.

PLEASE ATTACH THE INITIAL OBSTETRICAL EVALUATION/EXAMINATION AND SUBMIT TO THE ADDRESS ABOVE. MATERNITY RELATED CLAIMS OR REIMBURSEMENTS CANNOT BE PROCESSED WITHOUT THE SUBMISSION OF THIS FORM.