STEP ONE
For a Healthy Pregnancy

Prenatal Care Application

FOR OFFICE USE ONLY
First Appointment: ________________
Facility or Doctor: ________________
Home Visiting: Y or N ______________

Name of Client____

(Last) (First) (Middle Initial)

Date of Birth___________ **Gender:** ☐ Male ☐ Female ☐ Transgender M-F ☐ Transgender F-M

Sexual Orientation: ☐ Heterosexual ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Homosexual ☐ Questioning ☐ Other___________

Marital Status: ☐ Married ☐ Divorced ☐Single ☐ Widowed **Social Security Number** ____________________________

If married, does your spouse live in the home with you? ☐ Yes ☐ No

Street Address_____________________________________ **City**__________________ **State**____ **Zip**__________

I authorize Physicians CareConnection to send me text, email and voice messages. *This includes (but is not limited to) treatment- or care-related reminders and health education information.* ☐Yes ☐No

Telephone Number (Home): ______________________ **Cell Phone/Alt:** ___________________________

Email:____

Residency status? ☐ US Citizen ☐ Permanent ☐ Resident ☐ Visitor ☐ Student Visa

Emergency Contact: ____

(Name) (Relationship) (Phone)

Employed? ☐ Yes ☐ No **Employer**_______________ **Ethnicity** ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Race

__African
__African-American (Black)
__African-Somalian
__American Indian /Alaska Native
__Asian
__Asian Indian
__Caucasian (White)
__Chinese
__Filipino
__Guamanian / Chamorro
__Hispanic/Latino
__Japanese
__Korean
__Native Hawaiian
__Russian/ former Soviet Union
__Samoan
__Spanish
__Vietnamese
__Other________________________

When visiting a physician, do you need help speaking and understanding English? ☐Yes ☐ No

Is English your first language? ☐Yes ☐No **If no, please tell us what your first language is** ______________

Transportation: ☐ Has transportation ☐ Needs Bus Pass ☐ Needs Gas Asst. ☐ Occasionally needs transport ☐ None

Where did you hear about our program? ____

-OVER-

Rev. 03/2016

Send Completed Application to: 1390 Dublin Rd, Columbus, Oh 43215
Email to steponecolumbus@gmail.com or Fax to: 614-643-3813

STEP ONE
For a Healthy Pregnancy

Prenatal Care Application

FOR OFFICE USE ONLY
First Appointment: ________________
Facility or Doctor: _________________
Home Visiting: Y or N _______________

Please answer all questions by placing an [x] in one box next to the correct answer. Questions not answered may delay your application review process.

1. Do you currently have any health insurance? ☐ Yes ☐ No
   If yes, please indicate which one:
   ☐ Medicaid ☐ Medicare ☐ VA Benefits ☐ Private Health Insurance
2. If you have Medicaid, which plan do you have? MMIS/Billing Number ________________________________
   ☐ CareSource ☐ Molina ☐ United HealthCare Community Plan ☐ Buckeye ☐ Paramount ☐ None
3. Do you have a Case Manger/Worker? ☐ Yes ☐ No If yes, who is it? ____________________________
4. Has your pregnancy been confirmed by a medical professional, clinic, or health center? ☐ Yes ☐ No
5. Were you given a due date? ☐ Yes ☐ No If yes, what is the date? __________________
6. When was your last period? _________________
7. What trimester are you in? ☐ 1st (0-13 weeks) ☐ 2nd (14 to 26 weeks) ☐ 3rd (27 to 40 weeks)
8. Have you received any care for your pregnancy? ☐ Yes ☐ No If yes, where? __________________
9. How many times have you been pregnant? ________
10. If previous pregnancy:
    a. Were any of your previous babies born more than a month early (before 36 weeks gestation)? ☐ Yes ☐ No
    b. Did you ever deliver after 4 months along where the baby did not survive (16-36 weeks)? ☐ Yes ☐ No
    c. Have you ever been on progesterone? ☐ Yes ☐ No
    d. Have you ever had an ectopic pregnancy? ☐ Yes ☐ No
11. Do you have a primary care doctor? ☐ Yes ☐ No If yes, who is it? ___________________________________

12. Do you have any (current or history of) of the following medical or social conditions?

HIGH RISK:

CONDITION	YES	NO
Diabetes	☐	☐
Heart disease	☐	☐
High blood pressure	☐	☐
Kidney disease	☐	☐
Lung disease	☐	☐
Sickle cell	☐	☐
Taking medications for medical conditions (such as depression or anxiety disorders)	☐	☐
Are you having multiples	☐	☐
Seizure disorder	☐	☐
HIV Positive	☐	☐
Thyroid disease	☐	☐

RISK FACTORS:

CONDITION	YES	NO
Advanced maternal age (35 years or older)	☐	☐
Alcohol, drug, tobacco use , home or herbal remedies	☐	☐
Any physical disabilities (medically diagnosed)	☐	☐
Mental health conditions (not medicated)	☐	☐
Have you been diagnosed or are you being treated for any other medical conditions	☐	☐
Other conditions:		

Send Completed Application to: 1390 Dublin Rd, Columbus, Oh 43215
Email to steponecolumbus@gmail.com or Fax to: 614-643-3813