

Notification of Pregnancy Form

*Required Field

The earliest possible completion of this form allows us to best use our resources and services to help you and your patient achieve a healthy pregnancy outcome. **Please complete clearly in black ink and fax to 833-739-1744.**

Member's Current Contact Information							
*Member ID:		DOB (mmddyyyy):				
Last Name:		First Name	e:				
Mailing Address:							
City:	State:	Zip Cod	e:				
Home Number:	Cell Number:						
Email Address:							
OB Provider Information							
*OB Provider Name:							
*OB Provider TIN/ID #:							
OB Provider Mailing Address:							
OB Provider City:		OB Provider State	e:	OB Pro	ovider Zip	Code:	
OB Provider Phone Number:		Today's Date (mr	nddyyyy):				
General Information							
Primary insurance (for mom or baby) other than M	1edicaid? Yes	No					
*Due Date (mmddyyyy):	Dat	e of first prenatal visit	(mmddyy	/yy):			
Date of last Pap Smear (mmddyyyy):	Da	ate of last Chlamydia S	creening (mmddy	/уу):		
Race/Ethnicity (check all that apply):	casian, Non-Hispanic/	Latina Black/A	frican Am	erican	H	ispanic/La	tina
American Indian/Native American	Asian Hawaiian/Pacific Islander Other ethnicity (please specify					ease specify):	
If other ethnicity, please specify.							
Preferred Language (if other than English):							
Number of Full Term Deliveries:	mber of Preterm Deliv	veries:					
Number of Miscarriages/Abortions:	Number of Stillbirt	hs:					
Any social needs? Yes No							
If yes, please specify social needs:							
Enrolled in WIC? Yes No Planning	to Breastfeed? Ye	es No Heigh	t:				
Pre-Pregnancy Weight: Pre-Pregr	nancy BMI:		(Feet,	Inches)			
Age less than 16? Yes No Age gr	reater than 40?	Yes No					
*Are there any known pregnancy risk factors? © 2021 Ambetter of Oklahoma. All rights reserved.	Yes No						Rev. 09 13 2021 OP-PNOP-6282

*Member ID: DOB (mmddyyyy):
Last Name:
History
Previous Preterm delivery (<37 weeks)? Yes No If yes, was the delivery spontaneous? Yes No
Currently on 17P? Yes No
Recent delivery (within past 12 months)? Yes No Recent delivery (within past 6 months)? Yes No
Recent delivery (within past 12 months)? Yes No Recent delivery (within past 6 months)? Yes No Previous C-Section? Yes No Previous severe preeclampsia? 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
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 If yes, is high blood pressure well controlled? Yes No
Previous neonatal death or stillborn? Yes No
If yes, was neonatal death associated with an underlying maternal health condition? Yes No
HIV Positive? Yes No HIV Negative? Yes No HIV Test Refused? Yes No AIDS? Yes No
Seizure disorder? Yes No If yes, has there been a seizure within the last 6 months? Yes No
Current Pregnancy
Preterm labor this pregnancy? Yes No Current placenta previa? Yes No
Vaginal bleeding after 14 weeks? Yes No
Shortened Cervix <23 weeks this pregnancy? Yes No If yes, Length cm.
Current gestational diabetes? Yes No Current preeclampsia? Yes No Current oligohydramnios? Yes No
Current Twins? Yes No Current Triplets? Yes No Discordant growth? Yes No
Current fetal growth restriction? Yes No Current congenital anomalies? Yes No
BMI < 20 or poor weight gain during this pregnancy? Yes No UTI/Pyelo Bacteriuria this pregnancy? Yes No
Current severe hyperemesis? Yes No
Current mental health concerns? Yes No
If yes, please specify mental health concerns.
Current STD? Yes No If yes, please list STD's.
Current tobacco use? Yes No If yes, please specify amount used.
Current alcohol use? Yes No If yes, please specify amount used.
Current street drug use? Yes No If yes, please specify amount used.
Are there any other significant risk factors? Yes No
If yes, Please list other risk factors: