

# Information For Legal Documentation Of Birth

<b>PLEASE PRINT CLEARLY, THIS INFORMATION WILL BE TRANSFERRED TO YOUR BABY'S BIRTH CERTIFICATE. MAIL TO FAMILY ADVOCATE OR BRING IT IN WITH YOU.</b>				
MOTHER'S PRESENT NAME ( <i>First, Middle, Last</i> )		SS#	MAIDEN SURNAME	DATE OF BIRTH ( <i>Month, Day, Year</i> )
BIRTHPLACE ( <i>State or Foreign Country</i> )	RESIDENCE OF MOTHER (state in which she now lives)		COUNTY	CITY, SUBURB OR TOWNSHIP IN WHICH YOU ACTUALLY LIVE ( <i>Do not confuse this with your mailing address</i> )
STREET AND NUMBER		INSIDE CITY LIMITS <input type="checkbox"/> YES <input type="checkbox"/> NO	MOTHER'S MAILING ADDRESS ( <i>if same as residence, enter ZIP only</i> )	
FATHER'S NAME ( <i>First, Middle, Last</i> )		SS#	DATE OF BIRTH ( <i>Month, Day, Year</i> )	BIRTHPLACE ( <i>State or Foreign Country</i> )
MOTHER'S MARITAL STATUS AT TIME OF THIS CHILD'S BIRTH <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED			IF DIVORCE IS FINAL, IS IT 10 MONTHS OR LESS AT THE TIME OF THIS CHILD'S BIRTH?	
OF HISPANIC ORIGIN? ( <i>Specify No or Yes If Yes, specify Cuban, Mexican, Puerto Rican, etc.</i> )		RACE - American Indian, Black, White, etc. ( <i>Specify below</i> )		EDUCATION ( <i>Specify only highest grade completed</i> )
				ELEM./SEC (0-12)
				COLLEGE (1-4 OR 5+)
MOTHER <input type="checkbox"/> No <input type="checkbox"/> YES ( <i>Specify</i> )		MOTHER		MOTHER
FATHER <input type="checkbox"/> No <input type="checkbox"/> YES ( <i>Specify</i> )		FATHER		FATHER

<b>LIVE BIRTHS</b> ( <i>DO NOT INCLUDE THIS CHILD</i> )		OTHER TERMINATIONS (Spontaneous and induced at any time after conception)		DATE LAST NORMAL PERIOD BEGIN	MONTH OF PREGNANCY DOCTOR'S VISITS BEGAN	NUMBER OF VISITS (0, 1, 2, 3, ETC.)
		MISCARRIAGES ABORTIONS	STILL BORN	MONTH DAY YEAR	(1st, 2nd, etc.) IF NONE, STATE SO	
NOW LIVING	NOW DEAD	NUMBER	NUMBER	MOTHER'S PHONE NO.		
DATE OF LAST LIVE BIRTH ( <i>Month, Day, Year</i> )		DATE OF LAST OTHER TERMINATION ( <i>Month, Year</i> )				

**TO BE FILLED OUT BY THE NURSE AT THE TIME OF DELIVERY:**

CHILD-NAME	FIRST	MIDDLE	LAST	DATE OF BIRTH MONTH DAY YEAR	HOUR
SEX	BIRTH WEIGHT	DOCTOR'S ESTIMATE OF GESTATION		APGAR SCORE	
				1 MIN	5 MIN
DELIVERING DOCTOR			BABY'S DOCTOR		
BIRTH CERTIFICATE SENT					
DECLARATION OF PARENTAGE <input type="checkbox"/> COPIED			72 HOUR REPORT OF BIRTH TO A MINOR DATE SENT		