



**North Memorial  
Medical Center**

3300 OAKDALE AVENUE NO.  
ROBBINSDALE, MN 55422-9988

## BIRTH CERTIFICATE INFORMATION

<b>PLEASE PRINT CLEARLY, THIS INFORMATION WILL BE TRANSFERRED TO YOUR BABY'S BIRTH CERTIFICATE. BRING THIS FORM WITH YOU AND GIVE IT TO YOUR LABOR NURSE.</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 <i>(state in which she now lives)</i>		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	MOTHER
FATHER <input type="checkbox"/> No <input type="checkbox"/> YES <i>(Specify)</i>		FATHER		FATHER	FATHER

<b>LIVE BIRTHS</b> <i>(DO NOT INCLUDE THIS CHILD)</i>		OTHER TERMINATIONS <i>(Spontaneous and induced at any time after conception)</i>		DATE LAST NORMAL PERIOD BEGIN	MONTH OF PREGNANCY DOCTOR'S VISITS BEGAN	NUMBER OF VISITS <i>(0, 1, 2, 3, etc.)</i>
		MISCARRIAGES ABORTIONS	STILL BORN	MONTH      DAY      YEAR	<i>(1st, 2nd, etc.) IF NONE, STATE SO</i>	
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			<b>APGAR SCORE</b>		
						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				