Maternity Program Enrollment Form

Please take a few minutes to complete this health form and submit as soon as you can to start receiving the best benefits from the program.

For your participation in this free program during your pregnancy, Smithfield will mail you a gift card of **$200.00** after the delivery of your baby.

Demographic Information
Name:
Insurance ID#:
Current Mailing Address:
City/State/Zip Code:
Date of Birth:
How old will you be when your baby is born?
Race: [circle one] African American Asian Caucasian Hispanic Native American Other
Are You Married? Yes ___ No ___ If yes, do you give permission to discuss information with your spouse? Yes ___ No___ Name: _____
Highest Level of Education Completed: [circle one] 1 2 3 4 5 6 7 8 9 10 11 12 Degree: Associate's Bachelor's Master's Doctorate
Contact Information
Provide your contact information below: Phone: _____Home _____Cell Email Address: _____ Work (optional)
Do you prefer us to call you or email you?
What is the best time of day to reach you?
Doctor's name or the name of the practice:
Name of the hospital you plan to deliver:
How did you hear about the Maternity Management program? [circle one] Benefits Call Human Resources Clinic Health Fair Doctors Office Hospital Other: _____
What is your primary language?
Do you prefer to get educational information in: [circle one] English Spanish

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Employment Information

What is your employment status? [circle one] Full-Time Part-Time Not currently employed

If employed, describe the kind of work you do.

_____

_____

Do you do heavy lifting? Yes ____ No ____

Do you work with any chemicals? Yes ____ No ____

Do you have any work restrictions? Yes ____ No ____

What hours do you work? _____

Is Smithfield Foods your primary insurance coverage? Yes___ No____

If no, what is your primary coverage? _____

Do you receive WIC? Yes ____ No ____

Do you receive Medicaid? Yes ____ No _____

Do you receive Food Stamps? Yes ____ No_____

Pregnancy Information/History

When is your expected due date?

When was your first visit to the doctor? When is your next appointment?

Are you pregnant with more than one baby? Yes _____ No _____ If yes, how many? ____

Have you had an ultrasound? Yes ____ No ____ If yes, when?

Are you up to date on your pap smear? Yes ____ No ____ Unknown ___
(This is a screening test that checks for cervical cancer.)

Have you ever had an abnormal pap smear that required further testing or a biopsy?
Yes ____ No ____

Have you had any problems or complications with **this** pregnancy, like severe nausea/vomiting, bleeding, urinary tract infections, elevated blood pressures? Yes ___ No __
If yes, please explain:

How many times have you ever been pregnant?

How many babies have you delivered?

Please list age, type of delivery, and sex of children.

Age of child:	Vaginal or C-Section (if c/section please list reason) :	Boy/Girl:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever experienced a pregnancy loss? Yes _____ No _____
If so, how far along in the pregnancy? [circle one]
First 12 weeks Week 13-27 Week 28-40 unsure

If you have been pregnant before, did you have any complications listed below with a **previous** pregnancy?

Preterm labor: Yes ___ No ___ Preterm delivery: Yes ___ No ___

High blood pressure or preeclampsia: Yes ___ No ___

Gestational Diabetes or elevated blood sugars: Yes ___ No ___
If yes, could you please provide the year of the delivery and any additional information that may be helpful?

Are you: [circle one] Rh positive Rh negative Unknown

Are you planning to take a flu shot this year? Yes ___ No ___

What was your weight before you got pregnant?

How tall are you?

What is your current weight now?

Do you take a prenatal vitamin every day? Yes ___ No ___

Do you currently smoke? Yes ___ No ___
If so, how much a day?

Have you ever had any major surgeries? Yes ___ No ___
If so, please explain:

Do you handle any cat litter? Yes ___ (if so, please read below) No ___

Toxoplasmosis is an infection. It's caused by a parasite called Toxoplasma gondii. The parasite is so tiny you can't see it. You can be infected by touching cat feces. If you have toxoplasmosis within 6 months of getting pregnant, you may be able to pass it to your baby during pregnancy. Talk to your health care provider about being tested.

PLEASE COMPLETE THE FOLLOWING ABOUT YOUR HEALTH HISTORY

Do you have any of the following health conditions?	**Yes**	**No**	**Briefly Explain**
High blood pressure when not pregnant			
Lungs/Breathing-ex: asthma, COPD			
Stomach/Bowel issues			
Blood Disorders-ex: anemia, sickle cell			
Kidney disease			
Cancer			
Diabetes prior to pregnancy			
Depression or Anxiety			
Mental Health or Substance Abuse			
Have you been hospitalized in the **past year**?			
Do you get routine dental screenings twice a year?			Last exam date? Month: Year:
Do you have dental coverage through the Smithfield Health Plan?			
If no, would you consider asking about the dental coverage at your next open enrollment?			

Medications *(Please include prescriptions, over the counter medications vitamins and supplements)*	***Dosage*** *(milligrams, micrograms, units, etc.)*	***How often do you take it?*** *(once a day, twice a day, etc.)*	***What is the medication intended to treat?*** *(high blood pressure, diabetes, etc.)*

MID ATLANTIC HEALTH SOLUTIONS

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General Health Information

How many meals do you eat a day?

Do you eat foods high in calcium? Yes ___ No ___
Examples would be yogurt/milk/cheese/green leafy vegetables

How many drinks with caffeine do you drink a day? (Soda/Coffee/Tea)
none 1-4 5 or more

How many ounces of water do you drink a day?

Have you ever been diagnosed with depression? Yes ___ No ___

Have you ever been diagnosed with postpartum depression (baby blues)? Yes ___ No ___

Recently, have you had any of the following symptoms lasting more than 2 weeks:
[circle if **yes**]
severe, persistent sadness difficulty concentrating, remembering or making decisions

feeling hopeless, worthless or guilty loss of interest or pleasure in hobbies or activities

feeling tired not sleeping well irritability thoughts of harming yourself

sudden changes in appetite reckless behavior

How can you keep your baby safe from street drugs?

The best way to keep your baby safe from street drugs is to avoid them! Don't use street drugs. Talk to your health care provider. He can help you get treatment to help you quit.

Talk to your health care provider about treatment to help you quit. Or contact:

- National Council on Alcoholism and Drug Dependence
  (800) 622-2255
- Substance Abuse Treatment Facility Locator
  (800) 662-4357

What is abuse?

Abuse, whether emotional or physical, is never okay. Unfortunately, some women experience abuse from a partner. Abuse crosses all racial, ethnic and economic lines. Abuse often gets worse during pregnancy. Almost 1 in 6 pregnant women have been abused by a partner.

Tell someone you trust. This can be a friend, a clergy member, a health care provider or counselor. Once you've confided in them, they might be able to put you in touch with a crisis hotline, domestic violence program, legal-aid service, or a shelter or safe haven for abused women.

Note:

- **Please note**: Staff will reach out to you once this enrollment form is received. If you do not receive a follow up call within 10 days of faxing/mailing, please call 1-800-570-4888, Ext 408.
- After enrollment, to remain an active member of the Maternity Management program, you must stay in contact with us after each appointment. This can be by phone or email.
- After delivery, you will receive a survey to complete about your satisfaction with the program. Once that survey is returned, you will receive your $200.00 gift card via certified mail. Your Smithfield health coverage must be active at the time of delivery to receive the gift card.
- Staff is available to assist you Monday through Friday 8:30 am to 6:00 pm.
- **We would like to send you one of three book choices as a gift from us**. [**Please circle**] the one that you would like to receive from below.
  - What to Expect when you are Expecting (newest edition) – this reviews each month of the pregnancy through the post-partum period. This is great for first time moms and is available in English and Spanish.
  - What to Expect The First Year (newest edition) - this is a month by month guide of the baby's first year. It has excellent information on breastfeeding, formula feeding, immunizations, baby care, and milestones. This is available in English and Spanish.
  - Pregnancy, Childbirth and the Newborn: the complete guide – This book has great information on pregnancy, birth, the post-partum period, breastfeeding and newborn care. (This book available in English only; similar information in Spanish version, please see Spanish Enrollment form)
- Your health plan offers a breast pump benefit. Please ask the nurse for more information if you are interested!
- Ask us about how to get your Prenatal Vitamins Free!

I certify this information provided above is true and correct to the best of my knowledge.

Signature _____ Date _____

Please **sign** the PARTICIPATION RELEASE FORM and return it with your signed ENROLLMENT FORM by MAIL or FAX.

Fax: 757-562-3537

Mail to: Mid-Atlantic Health Solutions (**Please note extra postage may be required**)

Maternity Management Program

P. O. Box 494

Franklin, VA 23851

You may also call 1-800-570-4888 and complete the enrollment over the phone. Interpreter services are available.

Smithfield

MID ATLANTIC HEALTH SOLUTIONS

SMITHFIELD MATERNITY PROGRAM
PARTICIPATION RELEASE FORM

PATIENT NAME: _____

DATE OF BIRTH: _____

In order to allow my case manager to assist me with my health care needs and to discuss those needs with my health care providers, I give my permission to Smithfield Maternity program:

1. To contact my health care providers in regards to my medical needs in order to assist in the development of my Case Management Plan
2. To release verbal or written information that is related to my medical condition(s) to Smithfield Maternity Program in order to ensure a complete picture of my health care needs with the understanding that this information will assist in the coordination of my care.

This authorization will be valid for the complete period of time that I am enrolled in the Smithfield Maternity Program. I understand that any information that is communicated between my health care provider and Smithfield Maternity Program will be held in strict confidence and shall be used only for the purpose of case management.

My signature on this document shows that I understand the Case Management Program is completely voluntary and that I can choose not to participate at any time by telling my case manager I desire to withdraw from the program. Upon my request to withdraw from the Case Management Program, this authorization form is automatically null and void. I also understand that I am entitled to receive a copy of this form upon request to my case manager.

I agree with all the above conditions and wish to participate in Smithfield Maternity Program.

PATIENT SIGNATURE: _____

DATE: _____

Please sign, date and return **this form and the enrollment form**. You may make a copy for your records. You may mail or fax back. Thank you.