



Dear New Mother/Parent (woman giving birth),

The New York City Department of Health and Mental Hygiene issues your child's birth certificate. A birth certificate is the permanent legal record of your child's birth and is used as proof of your child's age, citizenship and parentage. The information you provide is required by law. Unless you complete this form correctly, we cannot create an accurate birth certificate for your child.

Information about education, race, smoking, height and your weight before pregnancy are collected for public health purposes. Additional questions labeled "QI" (Quality Improvement) are requested by the New York State Department of Health. New York City and State laws protect against the unlawful release of birth certificate information to ensure the confidentiality of you and your child.

- It is extremely important that you provide complete and accurate information to ALL questions. Please print all information clearly.
- The worksheet MUST be completed in English. If you are not able to complete it in English by yourself please call the hospital Birth Registrar at \_\_\_\_\_.
- The completed worksheet MUST be completed and returned to the Birth Registrar within 24 hours of the birth of your child.
- If you have any questions, please call the hospital Birth Registrar.

**For Facility Birth Registration Tracking Purposes**

**MOTHER/PARENT WORKSHEET - DATA COLLECTED FOR REGISTRATION OF NEWBORN BIRTH CERTIFICATE**

Mother/Parent's MRN:

Mother/Parent's Name:

Child's MRN:

Child's DOB:

Number delivered this pregnancy

If more than one, birth order of this child

Please print all names *exactly* as you would like them to appear on the birth certificate.  
 To change this information in the future, you will be required to submit a correction application to the Health Department.

**CHILD** If more than one child delivered, birth order of this child: \_\_\_\_\_

1. What will be your baby's LEGAL NAME?	Child's FIRST Name	Child's MIDDLE Name(s)	Child's LAST Name	Suffix <i>(Jr., III, etc.)</i>
2. Do you want a Social Security number and card for your child? <span style="float:right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> <small>As long as you have provided the legal <i>first and last</i> name of your newborn child above, you may request a Social Security number (SSN) for your child. The Health Department will send the request to the Social Security Administration at the time the certificate is filed. If you do not request this <i>now</i>, you will need to contact Social Security directly to obtain an SSN for your child. The hospital, birth facility and Health Department will not be responsible for making the request on your behalf.</small>				

**MOTHER/PARENT (WOMAN GIVING BIRTH)**

3. What is your CURRENT LEGAL name?	Mother/Parent's First Name	Mother/Parent's Middle Name	Mother/Parent's Legal Last Name
4. What is your MAIDEN name? <i>Name prior to first marriage</i>	<input type="checkbox"/> My maiden name is my current legal name Mother/Parent's First Name      Mother/Parent's Middle Name      Mother/Parent's Maiden Last Name		
5-7. What is your DATE OF BIRTH, current AGE and SEX?	Date of Mother/Parent's Birth ____ / ____ / ____ <small>Month Day Year</small>	Current Age ____	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male
8. What is your SOCIAL SECURITY NUMBER? <small>Providing parents' Social Security numbers is required by Federal Law, 42 USC 405(c) (\$205 (c) of the Social Security Act). The numbers will be made available to the NYS Office of Temporary and Disability Assistance to assist with child support enforcement activities and to the Internal Revenue Service through the Social Security Administration for the purpose of determining Earned Income Tax Credit compliance.</small>	Mother/Parent's SSN <input type="checkbox"/> I don't have a SSN _____ - _____ - _____ <small>Father/Parent's SSN will be requested in the Father/Parent's information section, if applicable.</small>		
Your signature below indicates that the information regarding the Social Security number on this form is correct.		Date	
Mother/Parent's Signature		____ / ____ / ____ <small>Month Day Year</small>	

**MOTHER/PARENT'S BIRTHPLACE**

9. Where were YOU BORN?	City	State <i>(If not in U.S., please indicate foreign country)</i>	Foreign Country
10. If you were born outside of the United States, how long have you lived in the U.S.?	<input type="checkbox"/> Never lived in U.S. <small>(go to next question)</small> Years lived in U.S. ____      OR      If less than one year:      Months lived in U.S. ____		

**MOTHER/PARENT'S ADDRESS**

11. Where do you USUALLY LIVE? <small>Where is your household physically located?</small>	Street Address <i>(Do NOT enter a PO Box or In Care of (c/o))</i>	Apt. Number	If NYC, County <i>(borough)</i>
<i>If not in U.S., please indicate foreign address, city and country.</i>	City	State	<input type="checkbox"/> New York <i>(Manhattan)</i> <input type="checkbox"/> Bronx <input type="checkbox"/> Kings <i>(Brooklyn)</i> <input type="checkbox"/> Queens <input type="checkbox"/> Richmond <i>(Staten Island)</i>
Do you live within the city limits specified above? <input type="checkbox"/> Yes <input type="checkbox"/> No      Outside NYC <i>(Specify County):</i> _____			
12. What is your MAILING address? <small>This is where the birth certificate will be MAILED. The first copy of the birth certificate is FREE.</small>	<input type="checkbox"/> Same as my USUAL residence above <input type="checkbox"/> No mailing address <i>If no mailing address, certificate will NOT be mailed; you will need to pick it up at the Health Department.</i> <i>If mailing address is In Care of (c/o), please indicate here:</i> In Care of <i>(another person or organization/agency)</i> _____		
Street Address <i>(PO Box is not permitted in a NYC mailing address)</i>		Apt. Number	
City		State	ZIP Code
Country			
13. What are your TELEPHONE numbers?	Day (____) _____ - _____ Ext. _____ Evening (____) _____ - _____		

## MOTHER/PARENT'S ATTRIBUTES

<p>14. EDUCATION: What is the highest level of school that you COMPLETED at the time of your baby's delivery? <i>Check (X) ONE box only</i></p> <p>15. Were you EMPLOYED during the pregnancy?</p> <p>16. What is your current/most recent OCCUPATION (job)?</p> <p>17. What INDUSTRY did you perform this occupation (job)? <i>Do not give the name of the business, but write what type of business it is.</i></p> <p>18. What is your ANCESTRY? <i>Check (X) ONE box and specify what you most consider yourself to be.</i></p> <p>19. What is your RACE? <i>Race is defined by U.S. Census. Hispanic is not a race according to the U.S. Census. For Hispanic ancestry, please use Question 18.</i> <i>Check (X) ALL that apply and specify where indicated.</i></p>	<input type="checkbox"/> 8th grade or less; none <input type="checkbox"/> 9th-12th grade, no diploma <input type="checkbox"/> High school graduate or GED <input type="checkbox"/> Some college credit, but no degree	<input type="checkbox"/> Associate degree (e.g. AA, AS) <input type="checkbox"/> Bachelor's degree (e.g. BA, AB, BS) <input type="checkbox"/> Master's degree (e.g. MA, MS, MEng, MEd, MSW, MBA) <input type="checkbox"/> Doctorate (e.g. PhD, EdD) or Professional degree (e.g. MD, DDS, DVM, LLB, JD)	
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Occupation (For example: cashier, bank teller, nurse, attorney, etc.)		
	Industry (For example: restaurant, banking, health care, legal, etc.)		
	<input type="checkbox"/> <b>Hispanic</b> (For example: Mexican, Puerto Rican, Cuban, Dominican, etc.) Specify: _____ <input type="checkbox"/> <b>NOT Hispanic</b> (For example: Italian, African American, Haitian, Pakistani, Ukrainian, Nigerian, Taiwanese, etc.) Specify: _____		
<input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native (name of enrolled or principal tribe) _____ <input type="checkbox"/> Asian Indian _____ <input type="checkbox"/> Chinese _____		<input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian (specify) _____	<input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander (specify) _____ <input type="checkbox"/> Other (specify) _____

## MOTHER/PARENT'S HEALTH

<p>20. Did you participate in WIC during this pregnancy? <i>(Special supplemental nutrition for Woman, Infants and Children.)</i></p> <p>21. What is your HEIGHT?</p> <p>22. What was your PRE-PREGNANCY WEIGHT?</p> <p>23. Did you smoke CIGARETTES in the three months before or during this pregnancy?</p> <p>24. Did you use ALCOHOL during this pregnancy?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No																				
	Height _____ Feet _____ Inches      Pre-Pregnancy Weight _____ lbs.																				
	<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, what was the average number of cigarettes/day or packs/day you smoked during the following times? <i>Please answer below. Enter 0 if NONE during any of these periods</i> <table border="1"> <thead> <tr> <th>Time Period</th> <th>Number of Cigarettes per day</th> <th>OR</th> <th>Number of Packs per day</th> </tr> </thead> <tbody> <tr> <td>3 months before your pregnancy</td> <td>_____</td> <td></td> <td>_____</td> </tr> <tr> <td>First 3 months of your pregnancy</td> <td>_____</td> <td></td> <td>_____</td> </tr> <tr> <td>Second 3 months of your pregnancy</td> <td>_____</td> <td></td> <td>_____</td> </tr> <tr> <td>Third 3 months of your pregnancy</td> <td>_____</td> <td></td> <td>_____</td> </tr> </tbody> </table>	Time Period	Number of Cigarettes per day	OR	Number of Packs per day	3 months before your pregnancy	_____		_____	First 3 months of your pregnancy	_____		_____	Second 3 months of your pregnancy	_____		_____	Third 3 months of your pregnancy	_____		_____
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First 3 months of your pregnancy	_____		_____																		
Second 3 months of your pregnancy	_____		_____																		
Third 3 months of your pregnancy	_____		_____																		
<input type="checkbox"/> Yes <input type="checkbox"/> No																					

**Quality Improvement (QI) questions are asked for the New York State Department of Health. They are designed to learn more about the quality of prenatal care New Yorkers are receiving. All answers will be used for public health purposes only.**

<p>25. (QI) Did you receive PRENATAL CARE (medical care for this pregnancy) before admission for this delivery?</p> <p>26. (QI) How many times per week during your current pregnancy did you EXERCISE for 30 minutes or more, above your usual activities?</p> <p>27. (QI) Did you have any problems with your GUMS at any time during pregnancy, for example, swollen or bleeding gums?</p> <p>28. (QI) During your pregnancy, would you say that you were:</p> <p>29. (QI) Thinking back to just before you were pregnant, how did you feel about becoming pregnant? <i>Check (X) ONE box only</i></p>	<input type="checkbox"/> No Skip to Question 26 <input type="checkbox"/> Yes If yes, please answer the following: During any of your prenatal care visits, did a doctor, nurse, or other health care worker talk with you about any of the things listed below?															
	<table border="0"> <tr> <td>a) How smoking during pregnancy could affect your baby?</td> <td><input type="checkbox"/> Yes   <input type="checkbox"/> No</td> <td>e) Birth control methods to use after your pregnancy?</td> <td><input type="checkbox"/> Yes   <input type="checkbox"/> No</td> </tr> <tr> <td>b) How drinking alcohol during your pregnancy could affect your baby?</td> <td><input type="checkbox"/> Yes   <input type="checkbox"/> No</td> <td>f) What to do if your labor starts early?</td> <td><input type="checkbox"/> Yes   <input type="checkbox"/> No</td> </tr> <tr> <td>c) How using illegal drugs could affect your baby?</td> <td><input type="checkbox"/> Yes   <input type="checkbox"/> No</td> <td>g) How to keep from getting HIV (the virus that causes AIDS)?</td> <td><input type="checkbox"/> Yes   <input type="checkbox"/> No</td> </tr> <tr> <td>d) How long to wait before having another baby?</td> <td><input type="checkbox"/> Yes   <input type="checkbox"/> No</td> <td>h) Physical abuse to women by their husbands or partners?</td> <td><input type="checkbox"/> Yes   <input type="checkbox"/> No</td> </tr> </table>	a) How smoking during pregnancy could affect your baby?	<input type="checkbox"/> Yes <input type="checkbox"/> No	e) Birth control methods to use after your pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	b) How drinking alcohol during your pregnancy could affect your baby?	<input type="checkbox"/> Yes <input type="checkbox"/> No	f) What to do if your labor starts early?	<input type="checkbox"/> Yes <input type="checkbox"/> No	c) How using illegal drugs could affect your baby?	<input type="checkbox"/> Yes <input type="checkbox"/> No	g) How to keep from getting HIV (the virus that causes AIDS)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	d) How long to wait before having another baby?	<input type="checkbox"/> Yes <input type="checkbox"/> No	h) Physical abuse to women by their husbands or partners?
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_____ Times per week																
<input type="checkbox"/> Yes <input type="checkbox"/> No																
<input type="checkbox"/> Not depressed at all <input type="checkbox"/> A little depressed <input type="checkbox"/> Very depressed and did not receive help <input type="checkbox"/> Moderately depressed <input type="checkbox"/> Very depressed and did receive help																
<input type="checkbox"/> You wanted to be pregnant sooner <input type="checkbox"/> You wanted to be pregnant then <input type="checkbox"/> You wanted to be pregnant later <input type="checkbox"/> You didn't want to be pregnant then or at any time in the future																

**If you want the name of the child's father/parent to appear on the birth certificate you must provide accurate and complete information below and submit completed form to the hospital Birth Registrar.**

**AND**

- 1) If married, ask the hospital what is necessary to ensure your spouse's name appears as the legal father/parent of your child on the birth certificate; OR
- 2) If married and your spouse is NOT the father/parent of the child, speak with the hospital Birth Registrar; OR
- 3) If you are not married, both you and the father must sign an ACKNOWLEDGMENT OF PATERNITY in the presence of two unrelated witnesses; OR
- 4) If your circumstances are not covered by the above, speak with the hospital Birth Registrar.

**FATHER/PARENT'S INFORMATION FOR LIVE BIRTH**  
**To be Completed by Mother/Parent or Father/Parent**

**FATHER/PARENT**

<p><b>30. What is the NAME of your baby's father/parent prior to first marriage?</b>          Please write Father/Parent's name exactly as you would like it to appear on the certificate. To change this information in the future, you will be required to submit a correction application to the Health Department.</p>	Father/Parent's First Name	Father/Parent's Middle Name(s)	Father/Parent's Last Name	Suffix (Jr., III, etc.)
<p><b>31-33. What is the father/parent's DATE OF BIRTH, current AGE, and SEX?</b></p>	Date of Father/Parent's Birth ___ / ___ / ___ <small>Month Day Year</small>		Current Age ___	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male
<p><b>34. What is the father/parent's SOCIAL SECURITY NUMBER?</b>          Providing parents' Social Security numbers is required by Federal Law, 42 USC 405(c) (§205 (c) of the Social Security Act). The numbers will be made available to the NYS Office of Temporary and Disability Assistance to assist with child support enforcement activities and to the Internal Revenue Service through the Social Security Administration for the purpose of determining Earned Income Tax Credit compliance.</p>	Father/Parent's SSN ___ - ___ - ___		<input type="checkbox"/> Father/Parent does not have a SSN <i>Mother/Parent's signature on previous page confirms that the above SSN is correct</i>	

**FATHER/PARENT'S BIRTHPLACE**

<p><b>35. Where was the father/parent BORN?</b></p>	City	State (If not in US, please indicate foreign country)	Foreign Country
<p><b>36. If the father/parent was born outside of the United States, how long has he/she lived in the U.S.?</b></p>	<input type="checkbox"/> Never lived in U.S. (go to next question)		OR If less than one year:
	Years lived in U.S.	Months lived in U.S.	

**FATHER/PARENT'S ATTRIBUTES**

<p><b>37. EDUCATION: What is the highest level of school that the father/parent COMPLETED at the time of your baby's delivery?</b>          Check (X) ONE box only</p>	<input type="checkbox"/> 8th grade or less; none <input type="checkbox"/> 9th-12th grade, no diploma <input type="checkbox"/> High school graduate or GED <input type="checkbox"/> Some college credit, but no degree <input type="checkbox"/> Associate degree (e.g. AA, AS) <input type="checkbox"/> Bachelor's degree (e.g. BA, AB, BS) <input type="checkbox"/> Master's degree (e.g. MA, MS, MEng, MEd, MSW, MBA) <input type="checkbox"/> Doctorate (e.g. PhD, EdD) or Professional degree (e.g. MD, DDS, DVM, LLB, JD)
<p><b>38. What is the father/parent's current/most recent OCCUPATION (job)?</b></p>	Occupation (For example: cashier, bank teller, nurse, attorney, etc.)
<p><b>39. In what INDUSTRY did he/she perform this occupation (job)?</b>          Do not give the name of the business, but write what type of business it is.</p>	Industry (For example: restaurant, banking, health care, legal, etc.)
<p><b>40. What is the father/parent's ANCESTRY?</b>          Check (X) ONE box only and specify what father/parent most considers himself/herself to be.</p>	<input type="checkbox"/> <b>Hispanic</b> (For example: Mexican, Puerto Rican, Cuban, Dominican, etc.) Specify: _____ <input type="checkbox"/> <b>NOT Hispanic</b> (For example: Italian, African American, Haitian, Pakistani, Ukrainian, Nigerian, Taiwanese, etc.) Specify: _____
<p><b>41. What is the father/parent's RACE?</b>          Race is defined by U.S. Census. Hispanic is not a race according to the U.S. Census. For Hispanic ancestry, please use Question 40.          Check (X) ALL that apply and specify where indicated.</p>	<input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native (name of enrolled or principal tribe) _____ <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian (specify) _____ <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander (specify) _____ <input type="checkbox"/> Other (specify) _____