TEXAS
Health and Human Services | Texas Department of State Health Services

Birth Worksheet for Child's Birth Certificate

The information you provide on this worksheet is used to create your child's birth certificate. The birth certificate is a legal document that your child will use throughout his/her life to prove your child's age, citizenship, and parentage. The State of Texas safeguards against the unauthorized release of identifying information from birth certificates to protect the confidentiality of parents and their child.

Please __PRINT__ your responses carefully and accurately as errors are difficult and expensive to correct.

Newborn's Information

Record Type: □ Facility □ En-Route □ Surrogacy □ Foundling □ Home Birth	Plurality:	Birth Order:	Is Child Unnamed? □ Yes □ No

LEGAL First Name:	LEGAL Middle Name:	LEGAL Last Name:	Suffix:

Date of Birth (MM/DD/YYY): ___ / ___ / _____	Time of Birth: _ _ : _ _ □ AM □ PM	Sex: □ M □ F □ ?	Infant MR#:

Do you want a Social Security card for your baby?   □ Yes   □ No

Parent 1's Information

Parent 1 Title Preference?   □ Mother   □ Father   □ Parent

LEGAL First Name:	LEGAL Middle Name:	LEGAL Last Name:	Suffix:	Mother MR#:

Child Birth Location: □ Hospital or Birthing Center □ Other (Specify Below)

Child Birth Address (Number & Street):	Apt:	State: TEXAS	County:	Local Registrar:

City:	Zip Code:	Zip Ext:

□ Maiden same as legal?

MAIDEN First Name:	MAIDEN Middle Name:	MAIDEN Last Name:	Suffix:

Date of Birth (MM/DD/YYY): ___ / ___ / _____	Birth Place:	Social Security Number: _ _ _ - _ _ - _ _ _ _

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Parent 1's Marital Status (read carefully)

Single (choose ONLY one):	**Married** (choose ONLY one):
□ Never Married □ Widowed (date: __/__/____) □ Divorced (date: __/__/____)	□ I am formally married to the child's biological father. □ I am common-law married to the child's biological father. □ I am currently married to or have been married within 300 days to someone other than the child's biological father.

If you are not married to biological father, then the biological father can only be listed on the birth certificate if both parents complete an *Acknowledgement of Paternity*.

If you are formally married, your husband may be listed on the birth certificate.

If you are common-law married, your husband may be listed as father on the birth certificate. Completion of an *Acknowledgment of Paternity* is optional but encouraged to ensure establishment of paternity.

If you are married to someone other than the biological father or have been married to someone other than the biological father within 300 days of this child's birth, then the biological father can only be listed on the birth certificate if both parents complete an *Acknowledgment of Paternity* that includes a *Denial of Paternity* from the current or former husband.

Do you want to add a father to your child's birth certificate?	□ Yes	□ No
Did you sign an *Acknowledgement of Paternity* before child's birth?	□ Yes	□ No
Do you want to complete an *Acknowledgement of Paternity* now?	□ Yes	□ No
Do you want to withhold your address & Social Security number on the *Acknowledgement of Paternity*?	□ Yes	□ No
Date *Acknowledgement of Paternity* Signed (if applicable)	___/___/_____	

Presumed Father's Information (if applicable)

LEGAL First Name:	LEGAL Middle Name:	LEGAL Last Name:	Suffix:
Date of Birth (MM/DD/YYY): ___ / ___ / _____	Social Security Number: _ _ _ - _ _ - _ _ _ _	□ Address same as Parent 1's mailing address?	

Mailing Address Number & Street:	Apt:	State/Country:	City:	Zip Code:	Zip Ext:

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Parent 1's Information

Did you relinquish your rights to the child (i.e. adoption)? □ Yes   □ No

Relinquish Date: ___/___/_____

Was paternity genetic testing done for this pregnancy?   □ Yes   □ No

Highest Education Level:
- □ 8th grade or less
- □ 9th—12th grade
- □ High School graduate or GED completed
- □ Some college credit, but no degree
- □ Associate degree (e.g. AA, AS)
- □ Bachelor's degree (e.g. BA, AB, BS)
- □ Master's degree (e.g. MA, MS, MEng, MEd, MSW, MBA)
- □ Doctorate (e.g. PhD, EdD) or Professional degree (e.g. MD, DDS, DVM, LLB, JP)
- □ Unknown

Occupation:

Business/Industry:

Email:

□ Residence address in city limits?
□ Residence same as mailing?

Residence Address Number & Street:	Apt:	State/Country:	City:	Zip Code:	Zip Ext:

Mailing Address Number & Street:	Apt:	State/Country:	City:	Zip Code:	Zip Ext:

Are you Spanish/Hispanic/ Latino?
- □ No, Not Spanish/Hispanic/Latina
- □ Yes, Mexican, Mexican American, Chicano
- □ Yes, Puerto Rican
- □ Yes, Cuban
- □ Yes, Other Hispanic (specify) _____
- □ Unknown

Race:
- □ White
- □ Black or African-American
- □ American Indian or Alaska Native (Specify Tribe) _____
- □ Asian Indian
- □ Chinese
- □ Filipino
- □ Japanese
- □ Korean
- □ Vietnamese
- □ Other Asian (Specify) _____
- □ Native Hawaiian
- □ Guamanian or Chamorro
- □ Samoan
- □ Other Pacific Islander (Specify) _____
- □ Other (Specify) _____
- □ Unknown

Parent 2's Information

Parent 2 Title Preference? □ Mother □ Father □ Parent

LEGAL First Name:	LEGAL Middle Name:	LEGAL Last Name:	Suffix:

□ Maiden same as legal?

MAIDEN First Name:	MAIDEN Middle Name:	MAIDEN Last Name:	Suffix:

Date of Birth (MM/DD/YYY): ___ / ___ / _____	Birth Place:	Social Security Number: _ _ _ - _ _ - _ _ _ _

Highest Education Level:
□ 8th grade or less
□ 9th—12th grade
□ High School graduate or GED completed
□ Some college credit, but no degree
□ Associate degree (e.g. AA, AS)
□ Bachelor's degree (e.g. BA, AB, BS)
□ Master's degree (e.g. MA, MS, MEng, MEd, MSW, MBA)
□ Doctorate (e.g. PhD, EdD) or Professional degree (e.g. MD, DDS, DVM, LLB, JP)
□ Unknown

Occupation:

Business/Industry:

Email:

□ Address same as Parent 1's mailing address?

Mailing Address Number & Street:	Apt:	State/Country:	City:	Zip Code:	Zip Ext:

Are you Spanish/Hispanic/Latino?
□ No, Not Spanish/Hispanic/Latina
□ Yes, Mexican, Mexican American, Chicano
□ Yes, Puerto Rican
□ Yes, Cuban
□ Yes, Other Hispanic (specify) _____
□ Unknown

Race:
□ White
□ Black or African-American
□ American Indian or Alaska Native (Specify Tribe) _____
□ Asian Indian
□ Chinese
□ Filipino
□ Japanese
□ Korean

□ Vietnamese
□ Other Asian (Specify) _____
□ Native Hawaiian
□ Guamanian or Chamorro
□ Samoan
□ Other Pacific Islander (Specify) _____
□ Other (Specify) _____
□ Unknown

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Texas Health and Human Services | **Texas Department of State Health Services**

Intended Parent 1's Information (Surrogacy)

Intended Parent 1 Title Preference?	□ Mother	□ Father	□ Parent

LEGAL First Name:	LEGAL Middle Name:	LEGAL Last Name:	Suffix:

□ Maiden same as legal?

MAIDEN First Name:	MAIDEN Middle Name:	MAIDEN Last Name:	Suffix:

Date of Birth (MM/DD/YYY): ___ / ___ / _____	Birth Place:	Social Security Number: _ _ _ - _ _ - _ _ _ _

Marital Status: □ Never Married □ Married □ Married, but don't add husband to birth certificate □ Divorced □ Widowed □ Unknown	Medicaid Chip Name:
	Medicaid Chip Number:
	□ Residence address in city limits? □ Residence same as mailing?

Residence Address Number & Street:	Apt:	State/Country:	City:	Zip Code:	Zip Ext:

Mailing Address Number & Street:	Apt:	State/Country:	City:	Zip Code:	Zip Ext:

Intended Parent 2's Information (Surrogacy)

Intended Parent 2 Title Preference?	□ Mother	□ Father	□ Parent

LEGAL First Name:	LEGAL Middle Name:	LEGAL Last Name:	Suffix:

□ Maiden same as legal?

MAIDEN First Name:	MAIDEN Middle Name:	MAIDEN Last Name:	Suffix:

Date of Birth (MM/DD/YYY): ___ / ___ / _____	Birth Place:	Social Security Number: _ _ _ - _ _ - _ _ _ _

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The remaining pages should be completed by hospital or birthing center staff. This data will be used to populate the medical data portion of the birth certificate for the newborn. The medical data is required to be reported within five days of the birth. [HSC §192.003]

Parent 1's Medical Information

Was mother transferred for delivery? □ Yes □ No	If yes, from where?
Principal Source of Payment: □ Private Insurance (Blue Cross/Blue Shield, Aetna, etc) □ Medicaid/Chip (Pending or Not) □ Self Pay □ Other (Specify) _____ □ Indian Health Service □ Champus/Tricare □ Other Government (Federal, State, Local)	Did you receive WIC during this pregnancy? □ Yes □ No
	Medicaid Chip Name:
	Medicaid Chip Number:

Did you smoke cigarettes before or during this pregnancy? □ Yes □ No If yes, how many:

Three Months Before: Cigs/Day: ___ or Packs/Day: ___
First Three Months: Cigs/Day: ___ or Packs/Day: ___
Second Three Months: Cigs/Day: ___ or Packs/Day: ___
Last Three Months: Cigs/Day: ___ or Packs/Day: ___

Weight at Delivery:	Weight Pre-Pregnancy:	Height:	Date Last Normal Menses Began: ___ / ___ / _____

HIV Test Done Prenatally? □ Yes □ No If yes, when (check all that apply): □ First Trimester □ Second Trimester □ Third Trimester □ None □ Unknown HIV Test Done at Delivery? □ Yes □ No Infant Tested for HIV at Birth? □ Yes □ No	**Pregnancy History** (do not include this child. For multiple deliveries, do not include children born after this child): **A.** How many other children do you have **now alive**? _____ **B.** How many of your children were born **alive**, but have since **died**? _____ **C.** Please provide the date of your last **live** birth: ___/___/_____ **D.** How many other pregnancies resulted in a **non-live birth** (stillborn, miscarriage, abortion) _____ **E.** Please provide the date of your last **non-live born** pregnancy ___/___/_____

Parent 1's Medical Information

Prenatal Care

Did you receive prenatal care? □ Yes □ No
Date of first prenatal visit: __/__/____
Date of last prenatal visit: __/__/____
Total number of visits: _____

Source of Prenatal Care (check all that apply):
□ Public Health Clinic
□ Private Physician
□ Midwife
□ Other (Specify) _____
□ Unknown

Method of Delivery

Was delivery with forceps attempted but unsuccessful?   □ Yes   □ No   □ ?

Was delivery with vacuum extraction attempted but unsuccessful?
□ Yes   □ No   □ ?

Fetal presentation at birth?
□ Cephalic   □ Breech   □ Other

Final route and method of delivery?
□ Vaginal/Spontaneous □ Vaginal/Forceps
□ Vaginal/Vacuum □ Cesarean (Final Route)
□ Unknown

If cesarean, was a trial of labor attempted?
□ Yes   □ No

Infections Present or Treated During Pregnancy (check all that apply)**:**
□ Gonorrhea
□ Syphilis
□ Chlamydia
□ Hepatitis B
□ Hepatitis C
□ None of the Above

Risk Factors in this Pregnancy (check all that apply):
□ Diabetes (select one)
        □ Pre-Pregnancy (Diagnosis Prior to this Pregnancy)
        □ Gestational (Diagnosis in this Pregnancy)
□ Hypertension (select one)
        □ Pre-Pregnancy (Chronic)
        □ Gestational (PIH, Preeclampsia)
        □ Eclampsia
□ Previous Preterm Birth
□ Other Previous Poor Pregnancy Outcome (choose one)
        □ Perinatal Death
        □ Small for Gestational Age
        □ Intrauterine Growth Restriction
        □ Other (Specify) _____
□ Pregnancy Resulted from Infertility Treatment (Check All that Apply):
        □ Fertility-Enhancing Drugs
        □ Artificial Insemination
        □ Intrauterine Insemination
        □ Assisted Reproductive Technology - Vitro Fertilization (IVF)
        □ Assisted Reproductive Technology - Gamete Intrafallopian Transfer (GIFT)
        □ Other (Specify) _____
□ Mother Had a Previous Cesarean Delivery?
        □ If selected, how many? _____
□ Antiretrovirals Administered during Pregnancy or at Delivery
□ Cholecystitis
□ Prior Classical Cesarean
□ Prior Myomectomy
□ None of the Above
□ Unknown

Parent 1's Medical Information

Obstetric Procedures (check all that apply)**:**
□ Cervical Cerclage
□ External Cephalic Version (choose one):
　□ Successful
　□ Failed
□ Tocolysis
□ None of the Above
□ Unknown

Onset of Labor (check all that apply)**:**
□ Premature Rupture of the Membranes (Prolonged > 18 Hours)
□ Precipitous Labor (Less than 3 Hours)
□ Prolonged Labor (Greater than 20 Hours)
□ None of the Above
□ Unknown

Characteristics of Labor & Delivery (check all that apply)**:**
□ Induction of Labor
□ Augmentation of Labor
Steroids (Glucocorticoids) for Fetal Lung Maturation Received by the Mother Prior to Delivery
□ Antibiotics Received by Mother during Labor
□ Clinical Chorioamnionitis Diagnosed during Labor or Maternal Temperature is > 38 C (100.4 F)
□ Moderate/ Heavy Meconium Staining of the Amniotic Fluid
□ Fetal Intolerance of Labor Such That One or More of the Following Action Was Taken: In-Utero Resuscitative Measures, Further Fetal Assessment, or Operative Delivery
□ Epidural or Spinal Anesthesia during Labor
□ None of the Above (choose one)
　□ Other Complication Not Listed
　□ No Complication Determined

Maternal Morbidity (check all that apply):

□ Maternal Transfusion
□ Third or Fourth Degree Perineal Laceration
□ Ruptured Uterus
□ Unplanned Hysterectomy
□ Admission to Intensive Care Unit
□ Unplanned Operating Room Procedure Following Delivery
□ None of the Above

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Newborn's Medical Information

Is newborn living at this time?   □ Yes   □ No   □ Unknown
Is newborn being breast fed, even partially?   □ Yes   □ No
How many weeks pregnant were you at delivery? _____ weeks
APGAR Score (at 5 min): _____
APGAR Score (at 10 min): _____

Was infant transferred for delivery? □ Yes □ No	If yes, from where?	Was Infant Vaccinated with Hepatitis B Vaccine? □ Yes □ No
Infant Primary Care Physician:		Child Weight:

Do the parents consent for the newborn's immunization information to be included in the statewide Immunization Registry and to share the immunization information with registered providers?   □ Yes   □ No   □ ImmTrac form not signed

Abnormal Conditions (check all that apply)**:**
□ Assisted Ventilation Required Immediately Following Delivery
□ Assisted Ventilation Required for More than Six Hours
□ NICU Admission
□ Newborn Given Surfactant Replacement Therapy
□ Antibiotics Received by the Newborn for Suspected Neonatal Sepsis
□ Seizure or Serious Neurologic Dysfunction
□ Significant Birth Injury (Skeletal Fracture (s), Peripheral Nerve Injury, and/or Soft Tissue/Solid Organ Hemorrhage Requiring Intervention)
□ None of the Above

Congenital Anomalies (check all that apply)**:**
□ Anencephaly
□ Meningomyelocele/Spina Bifida
□ Congenital Diaphragmatic Hernia
□ Gastroschisis
□ Down Syndrome (choose one):
    □ Karyotype Confirmed
    □ Karyotype Pending
□ Suspected Chromosomal Disorder (choose one):
    □ Karyotype Confirmed
    □ Karyotype Pending
□ Cleft Lip with Cleft Palate
□ Cleft Palate Alone
□ Cyanotic Congenital Heart Disease
□ Omphalocele
□ Limb Reduction Defect (Excluding Congenital Amputation and Dwarfing Syndromes)
□ Hypospadias
□ None of the Above

Birth Attendant Name:

Birth Certifier Name:

Optional Signature of Parent(s):

Acknowledgement of Paternity Worksheet

The information you provide on this worksheet is used to create your *Acknowledgement of Paternity*. Mother, father, and presumed father information must be completed for each partial AOP.

Please **PRINT** your responses carefully and accurately because the *Acknowledgement of Paternity* is a legal document.

Newborn's Information

Record Type:
□ Pre-Birth (birth record is not filed yet)

□ Post-Birth (birth record is already filed)

Is Child Unnamed?   □ Yes   □ No

LEGAL First Name:	LEGAL Middle Name:	LEGAL Last Name:	Suffix:

Date of Birth (MM/DD/YYY):
____ / ____ / _____

Child Birth Location:
□ Hospital or Birthing Center   □ Other (Specify Below)

Child Birth Address (Number & Street):	Apt:	State: TEXAS	County:	Local Registrar:

Only city and county of birth are required	City:	Zip Code:	Zip Ext:

Mother's Information

LEGAL First Name:	LEGAL Middle Name:	LEGAL Last Name:	Suffix:

□ Maiden same as legal?

MAIDEN First Name:	MAIDEN Middle Name:	MAIDEN Last Name:	Suffix:

Date of Birth (MM/DD/YYY):
____ / ____ / _____

Social Security Number:
_ _ _ - _ _ - _ _ _ _

Single (choose ONLY one):	**Married** (choose ONLY one):
□ Never Married □ Widowed (date: __/__/____) □ Divorced (date: __/__/____)	□ I am formally married to the child's biological father. □ I am common-law married to the child's biological father. □ I am currently married to or have been married within 300 days to someone other than the child's biological father.

Mother's Information

Residence Address Number & Street:	Apt:	State/Country:	City:	Zip Code:	Zip Ext:

Do you want to withhold your address & SSN on the Acknowledgement of Paternity?
□ Yes   □ No

Father's Information

LEGAL First Name:	LEGAL Middle Name:	LEGAL Last Name:	Suffix:

Date of Birth (MM/DD/YYY): ___ / ___ / _____	Social Security Number: _ _ _ - _ _ - _ _ _ _	Have you had Paternity Testing? □ Yes □ No

□ Is your address same as mother's?

Residence Address Number & Street:	Apt:	State/Country:	City:	Zip Code:	Zip Ext:

Do you want to withhold your address & SSN on the Acknowledgement of Paternity?
□ Yes   □ No

Presumed Father's Information (if applicable)

LEGAL First Name:	LEGAL Middle Name:	LEGAL Last Name:	Suffix:

Date of Birth (MM/DD/YYY): ___ / ___ / _____	Social Security Number: _ _ _ - _ _ - _ _ _ _

□ Is your address same as mother's?

Residence Address Number & Street:	Apt:	State/Country:	City:	Zip Code:	Zip Ext:

Do you want to withhold your address & SSN on the Acknowledgement of Paternity?
□ Yes   □ No

MESSAGE FROM SOCIAL SECURITY

INFORMATION ABOUT WHEN YOU WILL RECEIVE
YOUR BABY'S SOCIAL SECURITY CARD

IMPORTANT: IF YOU HAVE NOT NAMED YOUR BABY, WE CANNOT ISSUE A SOCIAL SECURITY CARD

You should get your baby's Social Security card in about 3 weeks. It takes your State about 2 weeks to notify the Social Security Administration (SSA) about your baby's birth. After the birth is registered, SSA will issue your baby a Social Security number. The card will be mailed to you about one week after SSA is notified by the State of your baby's birth. Check with your local postal authorities about mailbox name requirements to ensure delivery.

Never pay a fee to get a Social Security card. If anyone asks for money to help you get a card, notify SSA immediately at 1-800-772-1213.

If your baby has medical problems, call SSA at the number shown above to find out if Supplemental Security Income (SSI) can help.

If you receive Social Security benefits, call the number shown above to find out if your baby may be eligible to receive benefits on your account.

If you are filing for Welfare or other public assistance benefits for your baby, <u>You will need the following information completed before you leave the hospital.</u>

This certifies that a Social Security number was requested for

_____
Name of Child

_____   _____
Signature of hospital official   Date

NOTE: Notify your caseworker when you receive your baby's card.

Form **SSA-2853-OP2** (08-2009) Destroy Prior Editions

UN MENSAJE DEL SEGURO SOCIAL

LA INFORMACIÓN SOBRE CUÁNDO RECIBIRÁ
LA TARJETA DE SEGURO SOCIAL DE SU BEBÉ

IMPORTANTE: SI NO HA PUESTO NOMBRE A SU BEBÉ, NO SE LE PUEDE EXPEDIR UNA TARJETA DE SEGURO SOCIAL

Usted debe recibir la tarjeta de Seguro Social de su bebé en aproximadamente 3 semanas. Su Estado tarda alrededor de 2 semanas en notificar a la Administración del Seguro Social sobre el nacimiento de su bebé. Después que se registre el nacimiento, el Seguro Social expedirá un número de Seguro Social a su bebé. Se le enviará a usted la tarjeta alrededor de una semana después que el Estado haya notificado al Seguro Social del nacimiento de su bebé. Verifique con su oficina de correos local sobre los requisitos de nombre en el buzón para asegurar el reparto de correo.

Usted nunca debe pagar para obtener una tarjeta de Seguro Social. Si alguien le pide dinero para ayudarle a obtener una tarjeta, infórmeselo al Seguro Social inmediatamente al 1-800-772-1213.

Si su bebé tiene problemas médicos, llame al Seguro Social al número que aparece arriba para averiguar si los beneficios de Seguridad de Ingreso Suplementario («SSI», sus siglas en inglés) le pueden ayudar. Si recibe beneficios de Seguro Social, llame al número indicado arriba para averiguar si su bebé podría tener derecho a recibir beneficios en su registro.

Si usted está solicitando pagos de bienestar público o cualquier otro tipo de ayuda pública para su bebé, necesitará completar la siguiente información antes de salir del hospital.

 Esto certifica que se pidió un número de Seguro Social para

_____

Nombre y apellido del niño

_____   _____

Firma del oficial del hospital   Fecha

NOTA: Notifique a su trabajador social cuando reciba la tarjeta de Seguro Social de su bebé.