TSS
Total Scholastic Solutions

Maternity Questionnaire

This form should be sent to TSS Assist at Assist@tssassist.com. The purpose of this Maternity Questionnaire is to help maximize your benefits and ensure facilities being chosen are equipped to handle labor and delivery accordingly. This Maternity Questionnaire should be completed by pregnant members between 18 weeks and 22 weeks pregnant.

A. PATIENT INFORMATION

Last Name: _____ First Name: _____

Alias Name (s): _____ Date of Birth (mm/dd/yyyy): _____ Policy ID Number: _____

Policyholder Name (Last, First, MI): _____

1) History of Previous Pregnancies (for the past 3 years; please leave blank if this is your first pregnancy):

Date of birth _____ High Risk ☐ YES ☐ NO

If yes, please explain. :_____

☐ Vaginal ☐ Cesarean Congenital Conditions ☐ Yes ☐ No If yes, please provide diagnosis: _____

Date of birth _____ High Risk ☐ YES ☐ NO

If yes, please explain. :_____

☐ Vaginal ☐ Cesarean Congenital Conditions ☐ Yes ☐ No If yes, please provide diagnosis: _____

Date of birth _____ High Risk ☐ YES ☐ NO

If yes, please explain. :_____

☐ Vaginal ☐ Cesarean Congenital Conditions ☐ Yes ☐ No If yes, please provide diagnosis: _____

2) **Expected date of Delivery**: _____ ☐ Vaginal ☐ Cesarean If Cesarean, please explain: _____

3) **Is this a multiple birth?** ☐ YES ☐ NO If yes, how many babies? (Twins, Triplets, Quads, etc.): _____

4) **Is this considered high risk pregnancy?** ☐ YES ☐ NO If yes, please explain: _____

5) **Has your baby been diagnosed with any congenital or medical conditions in utero?** ☐ YES ☐ NO

If yes, please explain or provide diagnosis: _____

6) **Do you have a history of congenital or other conditions that may affect your pregnancy?** ☐ YES ☐ NO

If yes, please explain: _____

7) Anticipated Amniocentesis or other testing to be performed (If tests are performed, results should be sent to TSS):

_____

_____

B. PHYSICIAN INFORMATION

Name (printed): _____ Date: _____

Facility: _____

Address: _____ Phone Number: _____

FRAUD WARNING

Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties. The above answers are true and correct to the best of my knowledge. I authorize any physician, medical institution, pharmacy, insurance company, employer, labor union, or association to release information to Total Scholastic Solutions (TSS) as required to properly pay all benefits, if any, due to me, my spouse, or any other dependents. A photocopy of this authorization shall be considered effective and valid as the original.

Patient Signature: _____ **Date:**____/____/____

Physician Signature: _____ **Date:**____/____/____ **STAMP:**