



Harmony ID# \_\_\_\_\_

Name \_\_\_\_\_ Birth date \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip \_\_\_\_\_ County \_\_\_\_\_ Phone \_\_\_\_\_

When is your due date? \_\_\_\_\_

If you have been pregnant before, did you have any problems with your previous pregnancies? And what were they (premature or full term, vaginal or C-section delivery, miscarriage, abortion etc.)? \_\_\_\_\_

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When did you start your prenatal care? (Circle) 1<sup>st</sup> trimester 2<sup>nd</sup> trimester 3<sup>rd</sup> trimester

Who are you seeing for prenatal care? \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

What hospital are you delivering at? \_\_\_\_\_

Do you have any health concerns or social concerns that might put you at risk during this pregnancy? If so, please describe: \_\_\_\_\_

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Please print this form and mail it to:  
Harmony Health Plan of IL, Inc.  
c/o Harmony Hugs  
200 W. Adams Suite 800  
Chicago, IL 60606