Healthy Beginnings Lactation

REGISTRATION FORM

(Please Print)

Today's date:	PCP:

MOM'S INFORMATION

Patient's last name: First: Middle:	Marital status (circle one)	Single / Mar / Div / Sep / Wid	OB/Midwife:

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Home Phone #: ( )

Street address:	Email Address:	Cell phone #: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Returning to work?
OB/Midwife at your delivery:	Hospital/Birth Facility:	Return to work date:

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Internet search	❑ Other

Reason for visit:

❑Breast/Nipple Pain ❑ Poor Nursing ❑ Slow Weight Gain

INSURANCE INFORMATION

(Please have your insurance card available for copying at the visit)

Primary Insurance:	Subscriber's Name	Subscriber's S.S. #	Birth date: / /

Subscriber ID:	Group #:	Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other:	Plan Name:

Name of secondary insurance (if applicable):	Subscriber's name:	Subscriber ID:	Group #:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

INFANT

Name:	DOB/Age:	Birth Weight:	Last Known Weight:
Infant Care Provider/Pediatrician:	Practice Name:	MD at last visit:	Phone: ( )

The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance. I also authorize Healthy Beginnings Lactation or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*