The Birth Center Holistic Woman's
Health Care Registration – Please Complete Both Sides

Date: _____

Patient Information

First Name	Middle Initial		Last Name
Gender F____ M____	Date of Birth	Age	SSN
Previous Last name if changed since your last visit			How did you hear about the Birth Center?
Marital Status ___ S ___ M ___ D ___ W	Occupation		
Address line 1			
Address Line 2			
City	State		Zip Country

Email – Please print clearly	Home phone	Cell phone
☐ I would like to be added to the email list	Office Phone	Office Extension
Emergency Contact:	Relationship to Patient	Home Phone
		Cell

Ethnicity – Check One ___ Non Hispanic ___ Hispanic and CHECK ONE BELOW

___African American	___ Asian	___Caucasian
___Native American or Native Alaskan	___Native Hawaiian or Other Pacific Islander	

Preferred Language ___ English ___ Spanish ___ Other please specify

Primary Insurance

Primary Insurance	ID #	Group #

Policy Holder for Primary Insurance	Date of Birth	SSN	Relationship to Policy Holder

Type: ___HMO, ___PPO, ___EPO, ___Private, ___Other	Co-Pay if Applicable $

Address of primary policy holders if different from above:

Secondary Insurance

Secondary Insurance	ID #	Group #

Policy Holder for Secondary Insurance	Date of Birth	SSN	Relationship to Policy Holder

Type: ___HMO, ___PPO, ___EPO, ___Private, ___Other	Co-Pay if Applicable $

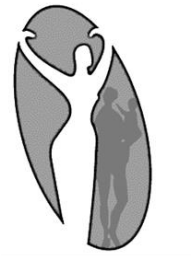
Address of secondary policy holder if different from above:

Office use

Insurance Card
Front

Office use

Insurance Card
Back



The Birth Center
Holistic Woman's Health Care

I hereby authorize The Birth Center to release any medical or other information that may be necessary for processing claims or that may be needed for my treatment.

Assignment of Insurance Benefits

I hereby authorize direct payment of medical benefits to the nurse midwives at The Birth Center for services rendered. I understand that I am financially responsible for any balance not covered by my insurance.

I understand it is also my responsibility to research with my insurance provider the need for any referrals they may require for my care.

A photocopy of these assignments shall be valid as the original.

PATIENT (please print): _____

SIGNATURE: _____ Date: _____

Medicaid or Medicaid Managed Care (if applicable)

SIGNATURE: _____ Date: _____

Destruction of Medical Records

With the exception of Medical records of minors (individuals under the age of 18 years), Medical records shall be preserved as original records for 7 years after most recent visit, after which time records may be destroyed. Pregnancy records are scanned into the Electronic Health Record system and Newborn records will be maintained for 21 years.

SIGNATURE: _____ Date: _____