The Birth Center Holistic Women's

Baby Registration

Date: ________________________

Baby's Information			
Baby's First Name	Middle Initial		Baby's Last Name
Gender F____ M____	Date of Birth	Age	* Mothers Full Name:
Mom's Date of Birth:			
Phone:			

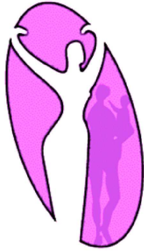
	Address:
*If baby is on dads insurance please indicate under **Policy Holder for Primary Insurance** below and dad's date of birth.	**Street:** ______________________________ **Apartment:** ______________________________ **City:** ______________ **State:** __________ **Zip:** _________

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		

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 Women'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.

PARENT (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: ______________________