PATIENT INFORMATION

Your Name _____Date of Birth _____

Address _____

City _____ Zip Code _____

County _____

Phone Number : Cell _____ Home _____

Email Address _____

May we add you to our electronic mailing list for class/support group updates? Yes No
Do you want to be a part of our CLOSED Facebook group for BRC clients? Yes No

Status: Single___ Married ___ Other ____

Name of Spouse/Partner

_____

Name of Baby _____ Baby DOB _____

Your Employer _____ Occupation _____

If student, School Name _____Full time_____Part-time ____

Hospital or birth center _____

OB/GYN or Midwife – Name and Practice Name

_____

Pediatrician – Name and Practice Name

_____

How did you hear about our center?

_____

Health Insurance Company _____

Insurance Plan or Program Name _____

Insurance ID Number _____Group Number _____

Are you the Primary Policy Holder? Yes _____ No _____

If no, name of Primary Policy Holder _____

Sex: M____ F ____

Primary's address, if different from above _____

_____

Primary's Date of Birth _____

Primary's Employer OR School _____

Your relationship to Primary Spouse_____ Child _____ Other _____

Is BABY covered by the insurance plan already listed? Yes_____ No _____

If NO: Baby's Health Insurance Company _____

Baby's ID (and Group) Number _____

Name of Policy Holder _____DOB _____

Policy Holder relationship to baby _____

Employer/School _____

Are YOU covered by a second health insurance plan? Yes _____ No _____

If YES: Name of Insurance Company _____

Insurance ID (and Group) Number _____

Name of Policy Holder _____

DOB _____

Policy Holder relationship to you _____

Policy Holder Employer/School _____

For funding purposes, we request information regarding your ethnic background. If you feel comfortable doing so, please circle the group with which you most closely identify:

White Black Hispanic/Latina Asian/Pacific Islander American Indian/Alaskan Native

Other _____