Around the Circle Midwifery, LLC

Client Registration Information

Name_____ Phone #_____Work # _____

Cell #_____ Other # (specify) _____

Date of Birth_____Social Security # _____

Address_____City_____State____Zip _____

E-mail address_____

Do you have a Health Savings Account or a Flexible Spending Account? Yes No (Circle One)

Primary Insurance:

Insurance company name _____

Insurance company address _____

Insurance company phone number _____

Subscriber number_____Group number _____

Name of policyholder_____Relationship to client _____

Policyholder's Date of Birth _____SS# of policyholder _____

Effective Dates: Coverage begins_____ Coverage ends_____

Secondary Insurance:

Insurance company name _____

Insurance company address _____

Insurance company phone number _____

Subscriber number_____Group number _____

Name of policyholder_____Relationship to client _____

Policyholder's Date of Birth _____SS# of policyholder _____

Effective Dates: Coverage begins_____ Coverage ends_____

I, _____, authorize the office of Around the Circle Midwifery to phone me at home / work / cell and leave a message. Personal details / lab results okay? Y / N

Signature _____ Date _____