2505 Main Street, Stratford CT 06615

Breastfeeding Resources Registration and Authorizations

203-375-5812

✓ **TODAY'S DATE:**____________________

✓ **Who referred you to us?**____

MOTHER INFO

Your Last Name First Name MI

DOB Age

Street Address

City State Zip

Main/Home Phone Cell Phone or 2nd number

Email address (Fax Number?)

Occupation Return to Outside Work? If yes, date

Employer Work Phone

Pharmacy Pharmacy Phone Number

MOTHER'S DOCTOR or other health care provider

(Your OB, midwife, internist, family doctor)

Provider's Last Name First Name

Practice Name Phone Number

Address

City State Zip

I authorize the exchange of information between Breastfeeding Resources and my health care provider

✓ **Signed**: ______________________________DATE___________

Patient's Signature

MOTHER'S HEALTH INSURANCE INFORMATION:

Primary Insurance Plan

Name of policy holder *(yourself or spouse?)*

Secondary Insurance Plan, if applicable

Name of policy holder *(yourself or spouse?)*

REFERRAL INFORMATION

✓ Does your insurance company require a referral? **YES NO**

✓ If so, has it been done? **YES NO**

I authorize payment of medical benefits to the health care providers at Breastfeeding Resources. I further authorize release to my insurance plan any medical or other information necessary to process the insurance claim(s).
I understand that payment is my obligation regardless of insurance or other third party involvement.

Signed: ________________________________DATE___________

Patient's Signature

INSURANCE CARDS:

Bring your insurance cards with you so we can photocopy them.
If you do not have your card, please fill in the lines to the right.
We will need this information for billing.

CHILD INFO

Child's Last Name First Name MI Sex

Date of Birth Due Date

✓ *Have you called your insurance to put baby on policy?* ***YES NO***

CHILD'S FATHER (and/or mother's spouse/partner)

Last Name First Name MI

DOB Age

Email address (Fax Number?)

Occupation Employer Work Phone

Cell or other phone Home address if not same

CHILDS'S DOCTOR or other health care provider

(Pediatrician, nurse practitioner, family doctor)

Provider's Last Name First Name

Practice Name Phone Number

Address

City State Zip

I authorize the exchange of information between Breastfeeding Resources and my child's health care provider

✓ **Signed**: ______________________________DATE___________

Parent's Signature

CHILD'S HEALTH INSURANCE INFORMATION:

Primary Insurance Plan

Name of policy holder *(yourself or spouse?)*

Secondary Insurance Plan, if applicable

Name of policy holder *(yourself or spouse?)*

REFERRAL INFORMATION

✓ Does your insurance company require a referral? **YES NO**

✓ If so, has it been done? **YES NO**

I authorize payment of medical benefits to the health care providers at Breastfeeding Resources. I further authorize release to my insurance plan any medical or other information necessary to process the insurance claim(s).
I understand that payment is my obligation regardless of insurance or other third party involvement.

Signed: ________________________________DATE___________

Parent's Signature

Insurance and Plan Name______________________________

ID# and Group Number______________________________

Co-pay Amount______________________________

Claims Address______________________________