

✓ TODAY'S DATE: \_\_\_\_\_

**MOTHER INFO**

Your Last Name First Name MI

DOB Age

Street Address

City State Zip

Main/Home Phone Cell Phone or 2<sup>nd</sup> 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 Upper Cumberland Lactation Services and my child's healthcare 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 the payment of medical benefits to the health care providers at Upper Cumberland Lactation Services. 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.**

✓ Who referred you to us? \_\_\_\_\_

**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

**CHILD'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 Upper Cumberland Lactation Services and my child's healthcare 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 the payment of medical benefits to the health care providers at Upper Cumberland Lactation Services. 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 \_\_\_\_\_