



Lynden Birth Center, LLC
Licensed Birth Center
200 3rd Street, Lynden, WA 98264
360-510-0188
FAX: 844-411-7474

Client Registration

Thank you for choosing to deliver your baby at the Lynden Birth Center. In order to register you, please fill out the following information completely and return to your midwife. *Thank you.*

Midwife's Name: _____
Client's Name: _____ Baby's Due Date: _____
Client's Birth Date: _____ Social Security#: _____
Street Address: _____
Mailing Address (if different): _____
Phone: HOME _____ CELL _____ WORK _____
Email: _____

INSURANCE INFORMATION:

Primary Insurance: _____ Insured Name: _____
ID Number: _____ Group Number: _____
Secondary Insurance: _____ Insured Name: _____
ID Number: _____ Group Number: _____

ACKNOWLEDGEMENT AND INSURANCE PAYMENT AUTHORIZATION:

I certify that the information in this form is correct to the best of my knowledge. I hereby authorize Lynden Birth Center to be paid directly by my health insurance company. I also authorize Lynden Birth Center or any of its representatives to release any information necessary to process my insurance claim.

Signature of Client: _____ Date: _____

TO BE COMPLETED BY THE MIDWIFE:

Date faxed to Ingrid (non-DSHS): _____
Date of first office visit with midwife (Group Health Only): _____
Date faxed to BBC: _____

TO BE COMPLETED BY LYNDEN BIRTH CENTER:

Date Pre-Authorization Faxed: _____ Confirmed: _____
Date Faxed Back to LM after Authorization Obtained: _____