

Inlet Community Birth Program

New Client Information

Patient

Full Name: _____ (as shown on Care Card)

Surname on birth certificate: _____

Date of Birth: _____ Age at due date: _____

Care Card Number: _____

Address: _____

Postal Code: _____

Phone numbers: Home: _____ Preferred Message OK?

Cell: _____ Preferred Message OK?

Work: _____ Preferred Message OK?

Email: _____

How did you hear about us? Midwives Assoc. of BC ICBP web site Facebook

Friend/Family Other: _____

Partner

Full Name: _____

Age at due date: _____

Address (if different): _____

Postal Code: _____

Phone numbers: Cell: _____ Preferred Message OK?

Work: _____ Preferred Message OK?

Pregnancy information

First day of Last Menstrual Period (LMP): _____

Due Date (if known): _____

Family Doctor: _____ Phone: _____

Please list all other providers (doctor, midwife) you have received care from or have had lab work ordered by in this pregnancy: _____

For Office Use Only:

1st _____ 2nd _____ 3rd _____ Birth _____ PP _____ 2nd att _____ 1st ass _____