Snohomish Midwives
57 Cedar Avenue
Snohomish, WA 98290
877-869-6105
Fax: 360-563-2662

Client Intake

Client Information

Client Name: _____ EDD: _____
Client Address: _____
City: _____ State: _____ Zip Code: _____
Client Phone: _____(home) _____(work) _____(cell)
Client Date of Birth: _____Client SSN: _____ Client height:_____
Email Address: _____ Marital Status: _____

Highest level of school completed: _____
Employment Status: full-time/part-time/not working (circle one)
Place of employment: _____ Type of Work: _____

Spouse/Partner's Name: _____ Date of Birth: _____
Contact Number: _____ Place of Employment: _____

How did you hear about us? _____

Insurance Information

Name of Primary Insurance Company: _____

Address of Insurance Company: _____

Phone of Insurance Company: _____ Type of Plan: _____

Insurance ID #: _____ Group #: _____

Secondary Insurance? _____

*If you are not the subscriber for your insurance plan, please fill out the section below.

Subscriber Name: _____

Subscriber Address: _____

Subscriber Date of Birth: _____ Subscriber SSN: _____