

East Bay Pediatrics Medical Group

Child's Name: _____ DOB ____ / ____ / ____ Male/Female
First _____

Last _____

Birth Weight _____

Sibling(s) First Name: _____ First Name: _____

First Name: _____ First Name: _____

First Name: _____ First Name: _____

Address _____

Street _____

City/zip _____

Parent's Name: _____ Parent's Name: _____

SS# _____

SS# _____

DOB ____ / ____ / ____

DOB ____ / ____ / ____

Address (if different than above): _____

Address (if different than above): _____

Home Phone # _____ Home Phone # _____

Occupation _____ Occupation _____

Employer _____ Employer _____

Work Phone # _____ Work Phone # _____

Cell Phone # _____ Cell Phone # _____

Primary Email _____

Insurance Information:

Primary Insurance Co _____ Second Insurance Co _____

Subscriber Name _____ Subscriber Name _____

Subscriber # _____ Subscriber # _____

Group # _____ Group # _____

Copay _____ Copay _____

Name of Employer who provides benefits:

Primary Plan _____

Secondary Plan _____

I acknowledge receipt of: *East Bay Pediatrics Medical Group Financial and Billing Policies & East Bay Pediatrics Medical Group Notice of Privacy Practices*

Signature of Parent or Guardian

Principal Spoken language: English ____ *Other* _____

Print Name

Date