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www.eastbaypediatrics.com

New Parent Intake Form

Welcome! Please help us serve you better by providing the following information.

Last Name:_____ First Name:_____

Spouse/Partner:_____

Address:_____ City:_____ State & Zip Code:_____

Race (please circle at least one): American Indian or Alaska Native / Asian / Black or African American / Native Hawaiian or other Pacific Islander / White / Prefers not to answer

Ethnicity (please circle at least one): Hispanic or Latino / Not Hispanic or Latino / Prefer not to answer

Best phone number to call and send text message confirmations:_____

Email address for our patient portal:_____

Due date:_____ What hospital will you be delivering at ?_____

Are you interested in a prenatal interview?_____

Siblings Full Name & DOB:

_____

We follow the vaccine guidelines from the American Academy of Pediatrics.
Are your children vaccinated or do you plan on vaccinating?_____

We require patient records for their first appointments. Do you have medical records?_____

Did you have a specific doctor in mind? _____

Is your child and/or children due for their wellness exam?_____ If so, when are they due?_____

_____

Does your child and/or children have any major medical concerns that the provider should be aware of?

_____

Insurance Information: (Please send a copy of your insurance card with your intake form)

Insurance Plan Name:_____ Insurance ID#:_____

Group#_____ Subscriber Name & DOB_____

Employer Name:_____

We require a credit card on file for all of our patients. In order to deliver a more convenient and consistent payment experience, we will securely save your credit, debit, or FSA/HSA cards on file. Do you agree with the credit card on file policy? _____

Please email this completed form to newpatient.vm@eastbaypediatrics.com a coordinator will be in touch in 3-5 business days.