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 96 Davis Road, Suite 2, Orinda, CA 94563  
 (925) 438-1100  
[www.eastbaypediatrics.com](http://www.eastbaypediatrics.com)

**Patient Information Form**

Child's Name:		DOB:	
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Male	Female	Birth Weight	
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**Sibling(s)**

Name:		DOB:	
Name:		DOB:	
Name:		DOB:	

Address \_\_\_\_\_  
 Street City/zip

Parent's Name: \_\_\_\_\_ Parent's Name: \_\_\_\_\_  
 SS# \_\_\_\_\_ SS# \_\_\_\_\_  
 DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Address (if different than above): \_\_\_\_\_ Address (if different than above): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Confidential Communication Preference. **Please circle:** Home Phone / Cell Phone / Text / Email

**Primary Email** \_\_\_\_\_

Home Phone # \_\_\_\_\_ Home Phone # \_\_\_\_\_

Occupation \_\_\_\_\_ Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Employer \_\_\_\_\_

Work Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Cell Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

***I acknowledge receipt of: East Bay Pediatrics Medical Group Financial and Billing Policies, Immunization Policy, and Visit Policy which includes Privacy Practices***

\_\_\_\_\_  
**Signature of Parent/Guardian**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Primary language spoken: English \_\_\_\_\_ Other \_\_\_\_\_**