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Patient Portal Enrollment Form

Please clearly print the following information:

Parent/Guardian information:

First Name:_____

Last Name:_____

Email Address:_____

Relationship to patient:_____

Patient(s) Must be 12 years old and younger:

Patient Name:_____ Date of birth:_____

Patient Name:_____ Date of birth:_____

Patient Name:_____ Date of birth:_____

Patient Name:_____ Date of birth:_____

By signing this form you agree to have access to East Bay Pediatrics Medical Group (EBP) Patient Portal for the patients listed above and are solely responsible for keeping your username and password safe and secure.

Parent/Guardian Signature:_____ Date Signed:_____