



2999 Regent Street, Suite 325, Berkeley, CA 94705
96 Davis Road, Suite 2, Orinda, CA 94563
(925) 438-1100

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: American Indian or Alaska Native Asian Black or African American Native Hawaiian or other Pacific Islander White Prefers not to answer

Ethnicity: 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.