eastbaypediatrics

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New Patient Intake Form

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

Child's Full Name & Date of Birth:_____ Gender: Male Female Non-binary

Siblings Full Name & Date of Birth:_____

Race (check 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 (check at least one): Hispanic or Latino Not Hispanic or Latino Prefer not to answer

Parent/Guardian Full Name & Date of Birth:_____

Best phone number to call: _____ Email:_____

Spouse/Partner Full Name & Date of Birth:_____

Best phone number to call: _____ Email:_____

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

We follow the vaccine guidelines from the American Academy of Pediatrics.
Is your child(ren) vaccinated? _____ Does your child(ren) have a MyChart portal?_____

Name & Phone Number of Previous Pediatrician?_____

Did you have a specific doctor in mind? _____

Is your child(ren) due for a wellness exam?_____ If so, when are they due?_____

Does your child(ren) have any major medical concerns that the provider should be aware of?

_____

Insurance Information: (Please send a copy of your insurance card front & back 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.