East Bay Pediatric & Adolescent Medicine

Patient Information: Please PRINT and fill in ALL LINES

Primary Doctor:____

Patient Name: ____

Mailing Address: ____

Mailing Town State and Zip Code:_______________________________

Date of Birth: _____/_____/_________

Home Phone:(______)______-_________

Work Phone:(______)______-_________

Cell Phone: (______)______-_________

Email Address:_________________________________@__________

Race: ❑ Caucasian ❑ Hispanic ❑ African American ❑ Asian ❑ Other ❑ Refuse

Language spoken: ❑ English ❑ Other_______________________________

Vision of hearing impairment? ❑ Yes ❑ No ____________________________

Pharmacy name:____

Pharmacy address:____

Emergency Contact (NOT A PARENT):

Name: ____

Phone number: (______)______-_________ Cell phone number: (______)______-_________

Relationship: ____

Insurance information:

Primary Insurance Company name:________________________________

Subscriber Name: ____

Subscriber ID:____

Group number: ____

Secondary Insurance Company name: ______________________________

Subscriber Name: ____

Subscriber ID:____

Group number: ____

Billing Name and address if different than above:

Billing Name: ____

Billing Address: ____

Billing Town State and Zip Code: ________________________________