EAST BAY PEDIATRIC PRIMARY CARE, INC.

2324 Santa Rita Road, Suite 12
Pleasanton, CA 94566
Telephone: (925) 462-7700

REGISTRATION (Please Print)

PATIENT INFORMATION

Patient"s Name _____ Social Security Number _____

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Date of Birth _____ Sex ( ) Male ( ) Female

School/Day Care _____

Sibling Names and Ages _____

Emergency Contact _____ Phone # _____

PARENT/GUARDIAN INFORMATION

Mother/Guardian _____ Birth Date _____/_____/_____ SS# _____

Home Address _____ City _____ Zip Code _____

Home Phone # _____ CA ID # / Drivers Lic # _____

Employer _____ Business Address _____

Work Phone # _____ E-mail Address _____

Father/Guardian _____ Birth Date _____/_____/_____ SS# _____

Home Address _____ City _____ Zip Code _____

Home Phone # _____ CA ID # / Drivers Lic # _____

Employer _____ Business Address _____

Work Phone # _____ E-mail Address _____

INSURANCE INFORMATION

Insurance Coverage

Primary Coverage, Name of Carrier _____

ID # _____ Group # _____ Effective Date _____

Patient's Relationship to Insured _____ Insured Name _____

Secondary Coverage, Name of Carrier _____

ID # _____ Group # _____ Effective Date _____

Patient's Relationship to Insured _____ Insured Name _____

Referred by _____ ( ) Telephone Directory ( ) Other _____

AUTHORIZATION EXPLANATION OF BENEFITS

I hereby authorize my insurance company to pay any benefits due in regards to my child's medical treatment directly to East Bay Pediatric Primary Care, Inc. I authorize East Bay Pediatric Primary Care, Inc. to release my child's medical records to my insurance company, if necessary. I understand that I am responsible for all charges incurred for my child regardless of any medical insurance I have, and I understand that all charges are to be paid in full within 30 days of treatment. My son/daughter has my permission to be seen and to receive medical care/medication that might be necessary.

Signature of Parent/Guardian _____ Date _____