BERKELEY PEDIATRIC MEDICAL GROUP

1650 Walnut Street, Berkeley, CA 94709
(510) 848-2566

DATE:_____ DOCTOR: _____ Primary Spoken Language: _____

CHILD: _____ _____ Gender: M F
Last First MI Date of Birth

CHILD: _____ _____ Gender: M F
Last First MI Date of Birth

CHILD: _____ _____ Gender: M F
Last First MI Date of Birth

ADDRESS: _____ _____
Street City/Zip Primary Email (Activate Patient Portal Y or N)

PARENT: Mother_____ _____ _____ _____
(Circle one) Father Last First Date of Birth SS# Driver License #

PHONE: ( ) _____ ( )_____ _____
(Circle one) Primary: Cell or Home Secondary: Cell or Home Employer Name & Contact Number

ADDRESS: _____
(If different) Street City/Zip

PARENT: Mother _____ _____ _____ _____
(Circle one) Father Last First Date of Birth SS# Driver License #

PHONE: ( ) _____ ( )_____ _____
(Circle one) Primary: Cell or Home Secondary: Cell or Home Employer Name & Contact Number

ADDRESS: _____
(If different) Street City/Zip

INSURANCE: Please present insurance card for copying. Primary Insurance is through the parent whose birthday occurs first in the calendar year.

Primary: _____
Name of Insurance Name of Insured & relationship to patient Policy ID/Group number

Secondary:_____ _____
Name of Insurance Name of Insured & relationship to patient Policy ID/Group number

IN CASE OF AN EMERGENCY CONTACT: (Other than parent)

_____
NAME PHONE RELATIONSHIP

The information provided is confidential and is intended only for the use of Berkeley Pediatric Medical Group.

I acknowledge receipt of Berkeley Pediatric Medical Group Financial Policy.
I hereby authorize insurance payment be made directly to Berkeley Pediatric Medical Group for surgical or medical benefits.
The doctors of Berkeley Pediatric Medical Group and any doctors, hospitals or agents they may designate, have our permission to provide medical and surgical care for our child in our absence.

_____ _____ _____
Date Signature Print name