eastbaypediatrics

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Patient Information Form

Patient name & DOB:

Home address:

Sibling(s) Name & DOB:

Race (please circle 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 (please circle at least one): Hispanic or Latino / Not Hispanic or Latino / Prefer not to answer

***Please note any updates below*:**

Address_____ _____
Street City/zip

Parent's Name:_____ Parent's Name:_____

DOB_____/_____/_____ DOB ____/____/____
Address (if different than above): Address (if different than above):
_____ _____
_____ _____

Confidential Communication Preference. **Please circle**: Home Phone / Cell Phone / Text / Email

Primary Email _____ **Primary phone for text messages**:_____

Home Phone #_____ Home Phone # _____

Occupation _____ Occupation _____

Employer _____ Employer _____

Work Phone # _____ Work Phone # _____

Cell Phone # _____ Cell Phone # _____

_____ _____
Signature of Parent/Guardian ***Print Name***
Primary language spoken: English____ Other_____

Date_____