

BERKELEY PEDIATRIC MEDICAL GROUP

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

DATE: _____ DOCTOR: _____

CHILD: _____ Gender: M F
Last First MI Birth date

PARENT: Mother _____
Father Last First Date of Birth SS# Driver License #

ADDRESS: _____
Street City/Zip Email

PHONE: () _____ () _____ () _____
Home Cell Work

PARENT: Mother _____
Father Last First Date of Birth SS# Driver License #

ADDRESS: _____
Street City/Zip Email

PHONE: () _____ () _____ () _____
Home Cell Work

Insurance **Policy Holder's Name** **ID & Group Number** **Effective Date**

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

NAME PHONE RELATIONSHIP

NAMES OF SIBLINGS: _____

Previous Doctor: _____
Name City/State Phone Number

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

I hereby authorize insurance payment be made directly to Berkeley Pediatric Medical Group for surgical or medical benefits. I have read and understand the Financial Policy provided to me. A 1.5% interest charge will be applied each month to the patient balance 30 days past due. **Co-payments specified by the insurance are due at each visit. Failure to pay at the visit will result in a \$10 service charge.**

Signature (Insured)

Permission for Medical Care of a Minor:

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.

Parent/Guardian Signature Date

Parent/Guardian Signature Date