Bay Street Pediatrics New Patient Intake Sheet

Date: _____

Mother: _____ DOB: _____
Last Name First Name

Father: _____ DOB: _____
Last Name First Name

Address: _____
Street Town State Zip

Home Phone: _____ Mother's Cell: _____ Father's Cell: _____

Best Phone to Leave Message on: Home___ Mother's Cell ___ Father's Cell ____

Email:_____

Name of Insurance Carrier:_____

Insurance provided though an employer? ☐ Yes ☐ No

Name of Responsible Parent: _____ DOB: _____

Insurance ID#: _____

If you are expecting, which hospital do you plan to deliver at?: _____

Name of OB/GYN: _____

If you are a transfer - what practice are you transferring from? _____

What is the reason for leaving your current Practice? _____

If you are a transfer – are your children up-to-date with their immunizations? _____

Were your children ever patients here? ☐ Yes ☐ No

If yes, why did they leave? _____

Child/Children's names:

_____
First DOB

_____
First DOB

_____
First DOB

Who may we thank for referring you to Bay Street Pediatrics? _____