The Pediatric Group
250 N. Robertson Blvd., #404
Beverly Hills, CA 90211
contact@thepediatricgroupbh.com
Fax: 310-273-8654

Transfer Patient Intake Form

Child name and age: _____

Child name and age: _____

Child name and age: _____

Name of Parent/Guardian: _____

Phone Number: _____

Previous Pediatrician: _____

Reason for Transfer: _____

Insurance (PPO or HMO): _____

Please initial below, indicating that you understand and agree to the following office policies:

_____ I understand The Pediatric Group is a vaccinating office and follows the immunization schedule published by the CDC (we do not accommodate alternative vaccination schedules)

_____ Medical records are needed 72 hours prior to scheduling an initial appointment (notes from last physical, vaccination history, growth chart). Records should be faxed or emailed to our office.

_____ I understand the Pediatric Group has an Annual Administrative Assessment Fee

The Pediatric Group reviews transfer requests on a weekly basis to ensure we have ample space in our practice to accommodate children in various age ranges. We will contact you after this form has been returned and the review process is completed. Thank you!