Print Form

# Tamalpais Pediatrics

## Patient Registration Form

Reset Form

Your Child's Pediatrician

Today's Date

**Child's Full Legal Name**

Birthdate ◯ Male ◯ Female

Child's nickname

Home Phone

Home Address

Patient Cell phone

City State Zip

Parent Cell phone

◯ Mother ◯ Father

Business Address

Parent Cell phone

City State Zip

◯ Mother ◯ Father

**Parent Name**

Birthdate SSN

◯ Mother ◯ Father ◯ Guardian/Foster Parent

email

Address

☐ email contact is preferred

☐ same as home address

☐ Single ☐ Divorced ☐ Remarried ☐ Widow(er)

City State Zip

☐ Married ☐ Separated ☐ Domestic Partners

Employer Occupation Work Phone

Work Address City State Zip

**Parent Name**

Birthdate SSN

◯ Mother ◯ Father ◯ Guardian/Foster Parent

email

Address

☐ email contact is preferred

☐ same as home address

☐ Single ☐ Divorced ☐ Remarried ☐ Widow(er)

City State Zip

☐ Married ☐ Separated ☐ Domestic Partners

Employer Occupation Work Phone

Work Address City State Zip

**Stepparent Name**

◯ Stepmother ◯ Stepfather

**Stepparent Name**

◯ Stepmother ◯ Stepfather

**Sibling**

☐ sister ☐ brother ☐ Stepsister ☐ Stepbrother Birthdate

**Sibling**

☐ sister ☐ brother ☐ Stepsister ☐ Stepbrother Birthdate

**Sibling**

☐ sister ☐ brother ☐ Stepsister ☐ Stepbrother Birthdate

**Insurance** Group# Child's ID#

Policy Holder (required) Pol. Holder Driver's Lic.#

**Emergency Contact** (if parents cannot be reached) Phone #

**Nearest Relative** (not living with you) Phone #

Address City State Zip

**Previous Physician** Address Phone