Lamorinda Pediatrics

Patient Registration 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 ____ ◯ Mother ◯ Father

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) ☐ Married ☐ Separated ☐ Domestic Partners

City ____ State ____ Zip ____

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) ☐ Married ☐ Separated ☐ Domestic Partners

City ____ State ____ Zip ____

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 ____