

Lowry Pediatrics Registration Form (Please print clearly) If you have any questions please ask a receptionist.

Patient Information

Patient's Full Legal Name: _____ D.O.B _____

Address _____ City _____ STATE _____ ZIP _____

Home Phone _____ Cell/Alt _____ Sex: M F

Mother's Full Name _____ D.O.B _____ SSN _____

Father's Full Name _____ D.O.B _____ SSN _____

Emergency Contact Name and Phone _____

Is the patient of American Indian or Alaskan Native descent? _____ Yes _____ No

Insurance Information

Insurance _____ Primary Person Insured and address below _____

Address _____ City _____ ZIP _____

Employer _____ Primary Person Insured SSN _____

PLEASE LIST ALL CHILDREN IN THE FAMILY(INCLUDING CHILD BEING SEEN TODAY)

Child's Legal Name	DOB	Sex	Child's Legal Name	DOB	Sex
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_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Does your child/children live with both parents? YES ___ NO ___

Step Parent's Name and Phone Number _____

Step Parent's Name and Phone Number _____

RELEASE OF INFORMATION/ AUTHORIZATION FOR PAYMENT

I authorize my insurance company to pay benefits directly to this office. I understand that I am financially responsible for any services not covered by my insurance company. I will comply with the office financial policies, including payment in full at the time of service, unless other arrangements have been made through this office. I understand that if it becomes necessary to forward my account to a collection agency, I will be responsible for any outstanding balance as well as the costs of collection and pertinent attorney fees.

Printed Name/Relation to patient _____ Date _____

Signature _____