

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

Patient Information

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

Address _____ City _____ State _____ ZIP _____

Home Phone _____ Cell/Alt _____

Sex (Please circle): M F Gender Identity: _____

Race _____ (Please circle) Is the patient Hispanic or Non-Hispanic?

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

Parent #1 Full Name _____ D.O.B _____ SSN _____

E-mail _____

Parent #2 Full Name _____ D.O.B _____ SSN _____

E-mail _____

Financially Responsible Party or Primary Insured _____

Emergency Contact Name and Phone _____

Preferred Pharmacy _____ City, Zip, Cross Streets _____

Insurance Information

Insurance _____ Employer _____

Primary Insured Address (if different then above)

Address _____ City _____ State _____ ZIP _____

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

Child's Legal Name / DOB / Sex / Gender

Child's Legal Name / DOB / Sex / Gender

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

Step Parent's Name, DOB 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 _____