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

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

Is the patient of American Indian or Alaskan Native descent? ______Yes ______No

Mother's Full Name______________________________D.O.B_________SSN____________________

E-mail ____

Father's 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	Child's Legal Name DOB Sex
_______________________________________	___________________________________
_______________________________________	___________________________________

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_____________________________________