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Loretta M. Lowery, LCSW

3990 Old Town Ave. Suite 203 C
San Diego, CA 92110

Patient Information and Registration

Today's Date:_____

Name:_____ Date of Birth:_____

Home Address:_____

City:_____ State:_____ Zip:_____

Phone 1:_____ Phone 2:_____

Email: _____

Can a message be left at Phone 1? Yes/No Can a message be left at Phone 2? Yes/No

INCOME/EMPLOYMENT INFORMATION

Present Employer:_____ Length Employed:_____

Title or Occupation:_____

MEDICAL/EMERGENCY INFORMATION

Primary Care Physician:_____ Phone:_____

Medications _____

Emergency Contact:_____ Phone:_____

ASSIGNMENT OF INSURANCE BENEFITS and RELEASE OF INFORMATION

The undersigned hereby instructs:

Name of Carrier_____ Phone:_____

Name of Insured_____ Policy/Group #:_____

to send the benefits allowable under my policy directly to:

Loretta M. Lowery, LCSW
PO Box 711111
San Diego, CA 92171

I also hereby give my permission to the assignee to release to the insurance carrier any information necessary for the determination of benefits under my policy and information necessary for authorization of continued treatment. I also agree to pay any balance above the amount paid by my carrier up to the agreed upon fee for services rendered.

_____ _____

Signature Date Print Name