Storm
CLINIC

Today's date:				DOB:
PATIENT INFORMATION				
Patient's last name: First: Middle:				Primary Care Doctor:
Street address:		Social Security no.:		Home phone no.: ( )
P.O. box:	City:		State:	ZIP Code:
Occupation:	Employer:			Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box):

❑ Dr. _____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

PHARMACY INFORMATION	
(Please give your insurance card to the receptionist.)	
PRIMARY PHARMACY:	LOCATION OF PHARMACY:

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*