Patient Contact Information

Please answer the following questions:

Patient name______________________________ Date__________________

Date of Birth________________ Gender___________ Ethnicity_______________

Address____ Apt #________

City__________________ State_________ Zip________________

Phone____________________ Alternate phone_______________________

Email address____

Employer_______________________ Social Security #____________________________

Emergency Contact_________________ Relationship___________ Phone____________

How did you hear about our office? ____

Insurance Company___________________ Phone______________________

Primary Insured Member _______________ ID#_________________________

Date of Birth ___________________ SS#_________________________

Secondary Insurance Company________________ Phone_______________________

Primary Insured Member______________ ID#_________________________

Date of Birth___________________ SS#_________________________

I do hereby authorize the release of any medical information necessary to process all claims and request payment of any medical benefit be paid to Dr. Robert Storment, OD. I have reviewed the consent form, received the brochure entitled "Notice of Privacy Practices" and given my permission to Dr. Robert Storment, OD to use and disclose my health information in accordance with the consent and the notice provided. I understand I am financially responsible for all services not covered or denied by my insurance provider.

Patient Signature_______________________________ Date_________________

Legal Guardian Signature________________________ Date_________________