



THUNDERBIRD FOOTCARE

Podiatric Medicine & Surgery

PATIENT REGISTRATION

Patient Name: _____ Responsible Party Name: _____

Billing Address: _____ City, State, Zip: _____

Permanent Address: _____ City, State, Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____ Sex: M F Birthdate: _____ Age: _____

Patient SS#: _____ Resp. Party SS# _____ Relationship to patient: *Spouse Parent Other*

Referred by: _____ Phone _____

Primary Doctor Name & Phone: _____

If Injury Related to an Accident, Was it: Auto Accident Work Related Date of Injury: _____

Marital Status: *S M W D* Is Patient: Employed Full-time Student Part-time Student Other _____

Employer Name / Address / Phone: _____

What are you being seen for: _____ First Date of Symptoms: _____

Allergies: _____ Are you pregnant? Yes No

Emergency Contact: _____ Phone:(____) _____ Relationship to patient: _____

INSURANCE INFORMATION

Primary Insurance Co. Name _____ Secondary Insurance Co. Name: _____

Ins. Co. Address: _____ Ins. Co. Address _____

Policyholder's Name: _____ Policyholder's Name: _____

Relationship to Patient: _____ Relationship to Patient: _____

Employer: _____ Employer: _____

Policy #: _____ Group/Claim # _____ Policy #: _____ Group/Claim#: _____

Policyholder Sex: *F M* Birthdate: _____ Policyholder Sex: *F M* Birthdate: _____

Co-pay \$ _____ Deduct \$ _____ Verified: _____ Co-pay \$ _____ Deduct \$ _____ Verified: _____

LIFETIME INSURANCE AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize this physician/clinic to release any information, for insurance purposes, required in the course of my examination or treatment which shall include HIV, Communicable disease or drug abuse information.

SIGNED (Patient or Parent, if minor): _____ Date _____

AUTHORIZATION TO PAY

I hereby authorize payment directly to the business office of this physician/clinic for the surgical and/or medical benefits, if any, otherwise payable to me for services. I understand that I am financially responsible for the charges not covered by my insurance.

SIGNED (Patient or Parent, if minor): _____ Date _____

Dr. Stone Dr. Chiarelli