THURBER & THURBER, DPM PC
PATIENT REGISTRATION

Welcome to our office. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent.

PATIENT INFORMATION:

____ __________________
First Name M. I. Last Name Today's Date

Gender: M / F Birthdate ____________________ Social Security # ______________________

Mailing Address ____

City _________________________________ State ______________ Zip __________________

Home Phone ____________________________ Work Phone ___________________________

Cell Phone ____________________________ Email _____________________________________

Pharmacy ____

Primary Care Physician __________________________ Date Last Seen __________________

Referred By: ☐Physician ☐Friend/Patient ☐Internet ☐Newspaper Ad ☐Phone Book

Please circle one of the following below:

Marital Status: Single / Married / Divorced / Partner / Legally Separated / Widowed

Student Status: Not a Student / Part Time Student / Full Time Student

Employment Status: Full Time / Part Time / Not Employed

Employer ____

Legal Representative/Guarantor's Name, Relationship, Address and Phone Number (if under 18):
____
____

Contact Preferences: (Select your primary preference)

☐Telephone ⇨ Okay to leave messages with ☐Patient only
☐Patient and/or spouse
☐Anyone who answers
☐Mail ☐Email (Make sure you provided your email address above)

Emergency Contact ________________________________ Phone _______________________

These next questions are part of a government program used for reporting and your answers do not affect your treatment at this office in any way.

Primary Language Spoken: ☐English ☐Other ______________________________________

Race: ☐Caucasian/White ☐African American ☐Asian ☐American Indian or Alaska Native
☐Native Hawaiian
Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino

HEALTH INSURANCE INFORMATION

Please note that this office does not treatment Workers' Compensation cases. If you are here due to a Workers' Compensation injury, please see the receptionist regarding where to seek medical treatment.

Primary Insurance Carrier ____

Policy Number ________________________________ Group Number ____________________

Subscriber's Name/Relationship ____

Subscriber's Date of Birth _____________________________

Secondary Insurance Carrier ____

Policy Number ________________________________ Group Number ____________________

Subscriber's Name/Relationship ____

Subscriber's Date of Birth _____________________________

MEDICAL HISTORY

What is your foot or ankle complaint/concern and its location?

____
____
____
____

How long has this been a problem? ____

Treatment thus far: ____

ILLNESS/INJURY: (Please circle)

Y	N	High Blood Pressure	Y	N	Kidney Condition
Y	N	Diabetes	Y	N	Bleeding Disorder
Y	N	Peptic Ulcers/GI Bleeding	Y	N	Diverticulosis
Y	N	Heart Condition	Y	N	Thyroid Problem
Y	N	Epilepsy	Y	N	Lung Problems/Asthma
Y	N	History of Heart Murmur	Y	N	Tuberculosis
Y	N	Stroke	Y	N	Hepatitis/Type _________________
Y	N	Cancer: ________________	Y	N	Gallstones
Y	N	Liver Condition/Jaundice	Y	N	Arthritis/Type __________________
Y	N	Accidents/Broken Bones	Y	N	Gout
Y	N	Bone or Foot Infection	Y	N	Osteoporosis
Y	N	HIV/Aids			

Please list any medical conditions not mentioned above: ________________________________
____

Height ______________ Weight ______________ Shoe Size _________________

FAMILY HISTORY: Please list relationship to you of family members who have had:

Diabetes _______________ Heart Attack ________________ Arthritis/Type _______________
High Blood Pressure _______________ Stroke _______________ Other ___________________

MEDICATIONS: (Please list any medications you are taking and why)

____
____
____

ALLERGIES: (Please list allergies to any medications and type of reaction)

____
____

Allergic to: Latex? Y / N   Adhesive Tape? Y / N   Metals? Y / N   Betadine/Iodine? Y / N

Females: Are you or could you be pregnant? Y / N

OPERATIONS/HOSPITAL ADMISSIONS:

Year (Approx.):   Operations/Hospitalizations: Type of Anesthetic (if known):

____

____

____

____

Were there any complications involving these surgeries? Y / N (If yes, please list)

____

____

Have you ever had a blood transfusion? Y / N (If yes, please provide date) __________________

SOCIAL HISTORY:

Do you or have you ever smoked? No / Yes ⇨ Packs per day ______ How many years? ______
If you quit smoking, when? _____________________

Alcohol Use: ☐none ☐occasional ☐daily/amount _________________________

Type of shoe gear at work ______________________________________

Type of shoe gear when not at work ______________________________________

I certify that the above information is true and accurate to the best of my knowledge. Also, I hereby authorize you to release to my insurance company any information regarding the treatment of my present condition/illness/injury. I also understand that I am financially responsible for any balances remaining after insurance and for any service, supplies or products that are not covered by my insurance plan.

____   ______________________

Signature of Patient or Guardian   Date