InStride Foot & Ankle of the Carolinas

PATIENT INFORMATION Today's Date: _____

Last Name: _____ First Name: _____ Middle Initial: ___ Sex: M / F

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

E-mail: _____

Social Security Number: _____ Date of Birth: _____ Marital Status: S / M / D / W

Guardian: _____ Relationship: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Care Physician: _____ Group: _____ Date of last visit: _____

Preferred Pharmacy: _____

Employer: _____ Phone: _____ Occupation: _____

Please tell us how you heard about our office: _____ ***Referred by***: _____

INSURACE INFORMATION: (Please allow receptionist to photocopy your insurance cards and driver's license with photo ID)

Primary Insurance Plan: _____ Policyholder Name: _____

Policyholder DOB: _____

Relationship to Policyholder: _____

Secondary Insurance Plan: _____ Policyholder Name: _____

Policyholder DOB: _____

Receipt of Notice of Privacy Practices

I attest that I have read or reviewed a copy of the InStride Foot & Ankle of the Carolinas Notice of Privacy Practices

Sign: _____ **Date:** _____

Insurance Assignment and Release:

I certify that I have insurance coverage with the above listed company and authorize InStride Foot & Ankle of the Carolinas to submit claims to my insurance company for any services rendered to me. I assign all insurance benefits to be paid directly to InStride Foot & Ankle of the Carolinas. I understand that I am financially responsible for all chargers whether or not paid by my insurance. All balances to be paid in full within 30 days of service. InStride Foot & Ankle of the Carolinas may use my health care information and may disclose such information to the above named insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits of related services.

Sign: _____ **Date:** _____

Consent for Healthcare and Release of Medical Information:

I voluntarily consent to healthcare treatment from the physicians and staff at InStride Foot & Ankle of the Carolinas. I am aware that the practice of medicine is not an exact science and that no guarantees have been made to me regarding the results of treatment or the examinations by my caregivers. I consent to the use of health information about me for treatment and communication of healthcare operations. I have read this form and have had the opportunity to ask questions regarding my health care and treatment.

Sign: _____ **Date:** _____

Patient Name: _____ Date: _____

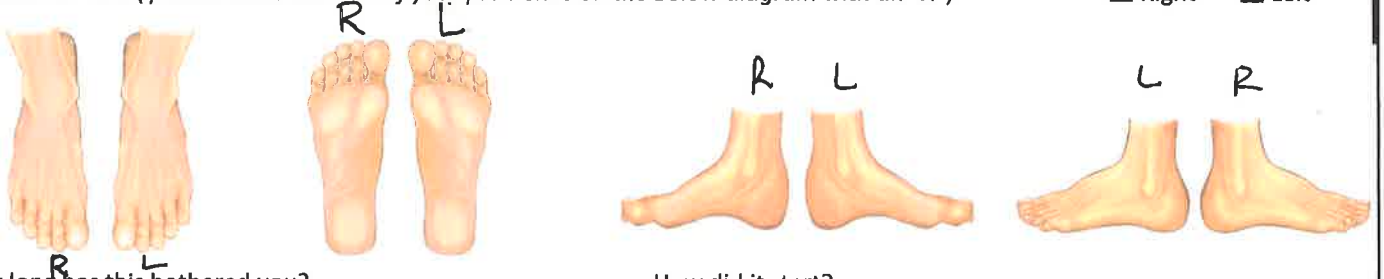
Age: _____ Height: _____ Weight: _____ Shoe Size: _____ Race: _____ Ethnicity: _____ Language: _____

CHIEF COMPLAINT: (nature of your problem or pain): _____

_____

If injury/Date of injury: _____ Work Related: Yes _____ No _____ Contact Administrator: _____

Location of Pain: (*please mark the area of your problem's on the below diagram with an "X")* ☐ Right ☐ Left



How long has this bothered you? _____ How did it start? _____

Can you describe the pain? ☐ Sharp ☐ Dull ☐ Burning ☐ Numbness ☐ Tingling ☐ Localized ☐ Radiating ☐ Swollen ☐ Hot

What aggravates it? _____ What relieves the condition? _____

Have you been treated for this condition by another Physician? yes____ no____ Physician/Date_____

Previous Medical History: (Please check if **You** or your *Family* are currently or have been treated for any of these in the past)

YOU *Family*	YOU *Family*	YOU *Family*	YOU *Family*	YOU *Family*
☐☐ Diabetes	☐☐ Heart Disease	☐☐ Arthritis	☐☐ Liver Disease	☐☐ Anemia
☐☐ Neuropathy	☐☐ Heart Attack	☐☐ Rheumatoid	☐☐ Hepatitis	☐☐ Anxiety/Depression
☐☐ Kidney Disease	☐☐ Pacemaker	☐☐ Lupus	☐☐ HIV	☐☐ Thyroid
☐☐ Dialysis	☐☐ Stroke	☐☐ Psoriasis	☐☐ Lung Disease	☐☐ Muscle Disease
☐☐ Cholesterol	☐☐ Blood Clot	☐☐ Gout	☐☐ COPD	☐☐ Bone Disease
☐☐ Hypertension	☐☐ Cancer	☐☐ Fibromyalgia	☐☐ Sleep Apnea	☐☐ Osteoporosis

Past Surgical History/Hospitalizations: (List surgery and date) Any Complications with anesthesia? ☐ yes ☐ no

_____

_____

Social History: Do you smoke Tobacco? ☐ No ☐ Yes Packs per day: _____ Years: _____ ☐ Former Smoker

Do you drink Alcohol? ☐ No ☐ Yes How often? _____

Women: Are you Pregnant/Breast feeding ? ☐ No ☐ Yes Are you claustrophobic ☐ No ☐ Yes

Medications: (Please include dosages if possible) ☐ Medication list provided

_____

Allergies: (Are you allergic or sensitive to any of the following) ☐ No Known Drug/Medication Allergies

☐ Penicillin ☐ Morphine ☐ Novocaine ☐ Latex ☐ OTHER: _____

☐ Sulfa ☐ Codeine ☐ Iodine ☐ Neosporin **REACTION** to allergen: _____

PHYSICIAN ENCOUNTER FORM

REVIEW OF SYSTEMS

Constitutional
- ☐ Fever
- ☐ Chills
- ☐ Fatigue
- ☐ Weight Change

Cardiovascular
- ☐ SOB
- ☐ chest pain
- ☐ Tachycardia
- ☐ Swelling

Musculoskelatal
- ☐ Arthralgia
- ☐ Back pain
- ☐ Muscle cramping
- ☐ Burning in feet

Neurological
- ☐ Dizziness
- ☐ Headaches
- ☐ Paresthesias
- ☐ Radiating pain

Endocrine
- ☐ Hair Loss
- ☐ Cold intolerance
- ☐ Polydipsia
- ☐ Numbness in feet

Gastrointestinal
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Acid Reflux

Hematologic
- ☐ Anemia
- ☐ Taking Coumadin
- ☐ Taking Aspirin
- ☐ Bleeding Disorder

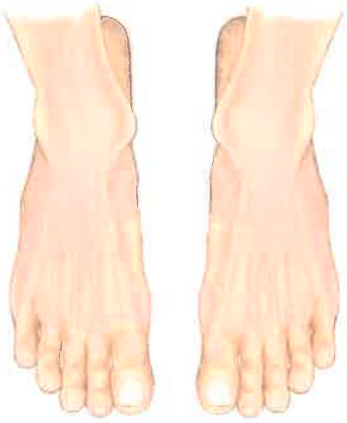
Genitourinary
- ☐ Frequent Urination
- ☐ Painful Urination
- ☐ Prostate issue
- ☐ Bladder issue

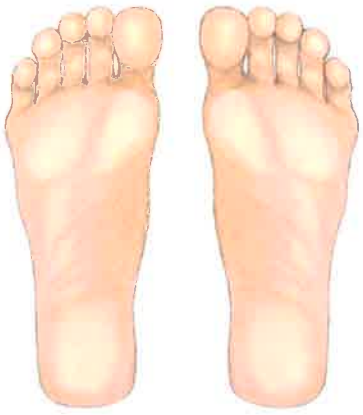
Respiratory
- ☐ Emphysema
- ☐ Bronchitis
- ☐ Asthma
- ☐ Cough

OB-GYN (women)
- ☐ Menopause
- ☐ Hysterectomy
- ☐ Taking Estrogen
- ☐ Irregular Periods

LOWER EXTREMITY PHYSICAL EXAM

INTEGUMENT:





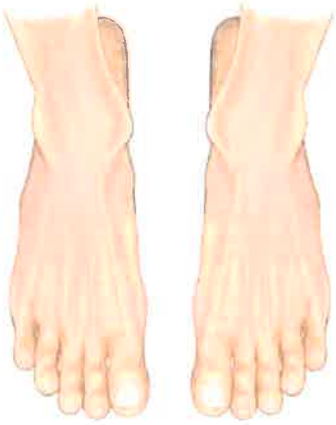
VASCULAR: Right __/__ DP __/__ PT

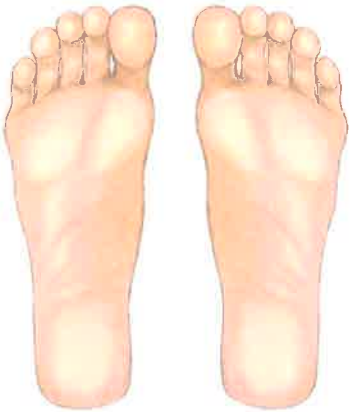
Right __/__ DP __/__ PT

NEUROLOGICAL: ☐ WNL __5.07 SWM

☐ WNL __5.07 SWM

MUSCULOSKELATAL:





IMAGING: X-RAY_____ Ultrasound_____ MRI_____ CT_____ Bone Scan_____

InStride Foot & Ankle of the Carolinas

Authorization for Release of Information

Name of Patient: _____ **Date of Birth:** _____

InStride Foot & Ankle of the Carolinas is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information Check each person/entity that you approve to receive information.	Description of information to be released Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Results of lab tests/x-rays ☐ Financial
☐ Spouse (Please provide name & Phone number) _____	☐ Financial ☐ Treatment
☐ Parent (Please provide name & Phone number) _____	☐ Financial ☐ Treatment
☐ Other (i.e, Stepparent, grandparent, nanny) _____	☐ Financial ☐ Treatment

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____ _____

Signature of Patient or Personal Representative **Date**

Our practice is a division of the InStride Foot & Ankle Specialists, PLLC. We have divisions across North and South Carolina, and we operate under one tax ID number. As such, **if you have seen any of the following physicians in the past three years, we need to know so that we will not file a new patient code for your visit today.** Since the insurance carriers look at us as one large practice, if you have been seen at any of the following divisions, you will not be considered a new patient in our practice. Visits prior to 2017 do not need to be disclosed. Please review the names of the divisions and podiatrists below and indicate if you have been seen at any of these divisions by putting a √ on the line to the left of the practice name. Thank you for disclosing this information to us – it will allow us to be in compliance with nationally mandated correct coding initiatives.

	Alta Ridge Foot Specialists (Resigned from Group 1/1/20)	Robert van Brederode, William Broyles, Thomas Verla
	Ankle & Foot Center of Charlotte (Resigned from group 7/1/17)	Scott Basinger
	Brunswick Foot & Ankle Surgery, PA	Joseph Kibler
	Capital Foot and Ankle Centers	Eldon Peters (eff: 10/1/2018)
	Carmel Foot Specialists (Resigned from group 1/1/20)	Barbara Kaiser, Richard Lind, Richard Miller, Kevin Molan, Tori Simmons-Lewis
	Carolina Foot & Ankle Health Center	Millicent Brown
	Carolina Foot Care Associates, PLLC	Ashma Davidson, Terry Donovan (ret 1/1/18), William O'Neill
	Carolina Podiatry Group	Brandon Percival, Julie Percival, William Harris, Katlin Jackson (eff:7/1/19), Robert Ezewuiro (eff:8/15/19)
	Central Carolina Foot & Ankle Associates	Melissa Hill, Gary Liao, Alan Sotelo
	Chapel Hill Foot & Ankle Associates, P.A.	Jane Andersen, Alan Bocko, Katherine Williams
	Charlotte Foot & Ankle Specialists, PLLC (Resigned from group 8/1/17)	Kristine Strauss
	Coastal Carolina Foot & Ankle	Thomas Hagan, Tyler Hagan
	Coastal Carolina Foot & Ankle Associates	Jeffrey Pupp(ret.12/31/2019), Kevin Bachman (eff: 1/1/2019), Derek Pantiel
	Comprehensive Foot & Ankle Center, P.A.	Zack Nellas
	Crystal Coast Podiatry	Thomas Bobrowski
	Family Foot & Ankle Center, P.A.	Patrick Dougherty, Doug Smith
	Family Foot Care	Kevin McDonald, Neil Younce (eff: 10/1/2019), Erin Younce (eff: 12/19/2019)
	Foot & Ankle Center of Durham	Eric Simmons
	Foot & Ankle of the Carolinas, PLLC	Eric Ward, Blaise Woeste
	Gaston Foot & Ankle Assoc., P.A (Resigned from group 12/1/19)	David Kirlin, Ryan Meredith, Wagner Santiago, Randell Contento
	Greensboro Podiatry Associates, P.A.	Martha Ajlouny, N'Tuma Jah (resigned 12/21/17), Jonathan Simpson (eff: 1/1/18) term 5/10/18
	Hendersonville Podiatry	Russ Barone(ret. 2/2/18), Pam Stover
	James Mazur, D.P.M., P.A.	James Mazur, Erin Younce (eff: 12/19/2019)
	Kinston Podiatry	Dale Delaney
	Matthews Foot Care	Brian Killian, Kevin Killian, David Ellenbogen(termed 10/23/19), Wesley Jackson (eff: 7/1/19)
	Mt. Airy Foot & Ankle Center, PLLC	Jim Shipley, David Collard, Walter Falardeau, Thurmond Siceloff (termed 10/23/2018) , Jeffrey Hunter (eff: 7/1/19)
	Myers Podiatric Clinic	William Myers
	Piedmont Foot & Ankle Clinic (Terming from Group 2/1/20)	Rick Hauser, Rob Lenfestey (ret.), Jason Nolan, Joel Kelly, Elizabeth Bass Daughtry, Jacob Panici, Brian Futrell (eff:3/1/18)
	Piedmont Podiatry Associates	Subodh Choudhary, Nicholas Canoutas, Cassandra Pike, Sarah Fitzgerald
	Queen City Foot & Ankle Specialists, P.C.	Roxanne Burgess, Alison Garten(termed 11/6/19), Wesley Jackson (eff: 7/1/19)
	Raleigh Foot & Ankle (Resigned from Group 1/1/18)	Alan Boehm, Robert Hatcher, Jordan Meyers, Kirk Woelffer
	Roberson Foot Care, PC	Ainsley Rusevlyan (eff: 2/1/2019)
	Ryan Foot & Ankle Clinic	David Garchar, Jeff Glaser, Michael Ryan, Scott Whitman, Matthew Borns, Bradley Lind (eff:7/23/19)
	Salem Foot Care	Scott Matthews
	Summit Podiatry	Derek Pantiel, Kevin Bachman
	Upstate Foot Care	Hans Blaakman
	Wake Foot & Ankle Center	Mike Hodos, Jim Judge
	Wilson Podiatry Associates, PA	Kendall Blackwell

____I attest that I have been seen in the above indicated division of the InStride since 01/01/2017.

____ I attest that to my best recollection, I have not been seen by any of the above divisions/physicians since 01/01/2017.

Signature of patient: _____ Date: _____