InStride Foot & Ankle Specialists℠ Mt. Airy | King | Winston-Salem | Clemmons | Greensboro | Siler City

PATIENT INFORMATION

Patient Name:_____ _____ _____ Date of Birth: ____/____/____ Age: ____ Sex: ☐ *M* | ☐ *F*
Last First MI

If other than patient, name of person in charge of appointments, payments, etc.: _____

Home Address: _____ City/State: _____ Zip: _____

Marital Status: ☐ *Single* | ☐ *Married* | ☐ *Partnered* | ☐ *Legally Separated* | ☐ *Divorced* | ☐ *Widowed*

How did you hear about us? ☐ *Doctor* | ☐ *Health Fair* | ☐ *Insurance* | ☐ *Google/Web* | ☐ *Friend/Family* | ☐ *Sign* | ☐ *TV*
☐ *Other:* _____

HOW CAN WE REACH YOU?

Primary Phone: _____ Type: _____ Secondary Phone: _____ Type: _____

E-Mail: _____ Primary Language: _____

Employer: _____ Occupation: _____

Primary Care Doctor/Practice: _____ Date of Last Visit: _____

Pharmacy: _____ Location: _____

OTHER CONTACTS:

Emergency Contact: _____ Relationship: _____ Phone #: (____) _____-_____

Due to HIPAA regulations, we will not share your private information with anyone without your consent. Is there a family member or other person you would like to grant permission to speak with us concerning your diagnoses, treatments, or bills?

☐ *Yes* | ☐ *No*

If yes, who? (Please list name and relationship): _____

If anyone other than you will be paying your bills, please complete the following:

Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone #: (____)____-_____

Do you have a Legal Guardian or Healthcare Power of Attorney? ☐ Yes | ☐ No

If yes, Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone #: (____)____-_____

***I acknowledge that I was provided a copy of the Notice of Privacy practices and that I have read (or had the opportunity to read if I so chose) and understand the notice.*

_____ _____
Print Name of Patient (Or Parent/Guardian) If other than patient, relationship to patient

_____ _____
Signature Date

Patient name: _____

MEDICAL HISTORY

Primary Care Doctor: _____ Date of Last Visit: _____

Pharmacy: _____ Location: _____

Height _____ Weight _____ Shoe Size _____

Circle if you have ever tested positive for any of the following: ☐ *TB* | ☐ *Hepatitis* | ☐ *HIV/AIDS* | ☐ *MRSA*

Do you have any known medication allergies? Please list: _____

_____

Other Allergies: ☐ *None known* | ☐ *Tape* | ☐ *Latex* | ☐ *Iodine* | ☐ *Shellfish* | ☐ *Foods/Other:* _____

Please attach or write a list of all medications you are currently taking (including prescriptions and over-the-counter medications).

_____

_____

_____

Please list all prior surgeries (include approximate date):

_____

_____

Have you ever had any of the following? (Please select Y or N)

Arthritis	☐ Y ☐ N	If you are diabetic, do you take Insulin? ☐ *Yes* | ☐ *No*
Cancer	☐ Y ☐ N	Last glucose reading: _____
Diabetes	☐ Y ☐ N	Last A1C Level: _____
Fibromyalgia	☐ Y ☐ N	Other conditions: _____
Gout	☐ Y ☐ N	_____
High Blood Pressure	☐ Y ☐ N	_____
Neuropathy	☐ Y ☐ N	_____

Please select any conditions in your **family's** medical history: ☐ *Cancer* | ☐ *Diabetes* | ☐ *Gout*
☐ *Heart Disease* | ☐ *High Blood Pressure* | ☐ *Stroke* | ☐ *Rheumatoid Arthritis*

SOCIAL HISTORY

Current or past tobacco use? ☐ *Never* | ☐ *Past use (smoked)* | ☐ *Past use (smokeless)*

Current Use -- Type _____ *Frequency:* ☐ *Rare* | ☐ *Occasional* | ☐ *Moderate* | ☐ *Daily*

Current or past alcohol use? ☐ *Never* | ☐ *Past use -- Quit* _____ *ago*

Current Use -- Type _____ *Frequency:* ☐ *Rare* | ☐ *Occasional* | ☐ *Moderate* | ☐ *Daily*

Current or past recreational drug use? ☐ *Never* | ☐ *Past use -- Quit* _____ *ago*

Current Use -- Type _____ *Frequency:* ☐ *Rare* | ☐ *Occasional* | ☐ *Moderate* | ☐ *Daily*

Patient name: _____

REVIEW OF SYSTEMS

Do you have any known medical conditions or current symptoms associated with:

Eyes: _____ Stomach: _____ Chest: _____

Ears: _____ Intestines: _____ Heart: _____

Nose: _____ Liver: _____ Lungs: _____

Throat: _____ Kidneys: _____ Other: _____

CURRENT PROBLEM

What *specific* problem brings you to our office today? (What part of your foot/ankle is causing trouble?)

_____

_____

What is your occupation? _____

Any hobbies or other activities that impact how you use your feet? _____

_____

Was this problem caused by an injury? ☐ *Yes* | ☐ *No* If yes, please explain:

_____

_____

_____

How long ago did this problem first start? _____

How would you describe your pain? ☐ *No pain* | ☐ *Sharp* | ☐ *Dull* | ☐ *Aching* | ☐ *Burning*

☐ *Radiating* | ☐ *Itching* | ☐ *Stabbing* | ☐ *Other* _____

Since your pain or problem began, has it: ☐ *Stayed the same* | ☐ *Become Worse* | ☐ *Improved*

What makes your pain or problem feel worse? ☐ *Walking* | ☐ *Standing* | ☐ *Resting* | ☐ *Dress Shoes*

☐ *Flat Shoes* | ☐ *Any Closed Toe Shoe* | ☐ *Running* | ☐ *Other* _____

What makes your pain or problem feel better? _____

What treatments/remedies have you tried for this problem? Has any of it worked?

_____

_____

Welcome, New Patients!

Our practice is a division of **InStride Foot & Ankle Specialists, PLLC**. We have divisions across North and South Carolina. Because of this, if you have seen any of the following physicians in the past **three years**, we need to know so that we can file your insurance appropriately. **Visits prior to 2018 do not need to be disclosed**. If you have been seen at any of the divisions below, please put a **√** on the line to the left of the practice name. Thank you for disclosing this information to us – this will allow us to be in compliance with nationally mandated correct coding initiatives.

InStride Foot and Ankle Specialist Piedmont Region Locations:

☐	Carmel Foot Specialists **(before 1/1/20)**	Barbara Kaiser, Richard Lind, Richard Miller, Kevin Molan, Tori Simmons-Lewis
☐	Carolina Foot Care Associates, PLLC	Ashma Davidson, Terry Donovan **(before 1/1/18)**, William O'Neill
☐	Carolina Foot & Ankle Health Center	Millicent Brown
☐	Capital Foot and Ankle Centers	Eldon Peters
☐	Carolina Podiatry (located in SC)	Brandon Percival, Julie Percival, William Harris, Katlin Jackson **(on/after 7/1/19)**, Robert Ezewuiro **(on/after 8/15/19)**
☐	Central Carolina Foot & Ankle Associates	Melissa Hill, Gary Liao, Alan Sotelo
☐	Chapel Hill Foot & Ankle Associates, P.A. **(before 9/1/20)**	Jane Anderson, Alan Bocko, Katherine Williams
☐	Comprehensive Foot & Ankle Center, P.A.	Zack Nellas
☐	Family Foot & Ankle Center, P.A. **(before 10/1/20)**	Patrick Dougherty, Doug Smith
☐	Family Foot Care	Kevin McDonald, Neil Younce, Erin Younce
☐	Foot & Ankle Center of Durham	Eric Simmons **(before 11/1/20)**
☐	Foot & Ankle of the Carolinas, PLLC	Eric Ward, Blaise Woeste
☐	Gaston Foot & Ankle Associates, P.A. **(before 11/1/2019)**	David Kirlin, Ryan Meredith, Wagner Santiago, Randell Contento
☐	Greensboro Podiatry Associates, P.A.	Martha Ajlouny
☐	James Mazur, D.P.M., P.A.	James Mazur, Erin Younce
☐	Matthews Foot Care	Brian Killian, Kevin Killian, David Ellenbogen (termed 10/23/19), Wesley Jackson
☐	Mt. Airy Foot & Ankle Center, PLLC	Jim Shipley, David Collard, Walter Falardeau, Jeffrey Hunter, Thurmond Siceloff **(before 10/23/2018)**
☐	Piedmont Foot & Ankle Clinic **(before 2/1/20)**	Rick Hauser, Rob Lenfestey, Jason Nolan, Joel Kelly, Elizabeth Bass Daughtry, Jacob Panici, Brian Futrell
☐	Queen City Foot & Ankle Specialists, P.C.	Roxanne Burgess, Wesley Jackson, Alison Garten **(before 11/6/19)**
☐	Raleigh Foot & Ankle **(before 1/1/2018)**	Alan Boehm, Robert Hatcher, Jordan Meyers, Kirk Woelffer
☐	Ryan Foot & Ankle Clinic **(before 7/1/2020)**	David Garchar, Jeff Glaser, Michael Ryan, Scott Whitman, Matthew Borns, Bradley Lind
☐	Wake Foot & Ankle Center	Mike Hodos, Jim Judge

****If you have seen a Podiatrist in NC or SC and their name is not listed above, please list that provider's name in the section below:

InStride Foot & Ankle Specialists℠

Mt. Airy | King | Winston-Salem | Clemmons | Greensboro | Siler City

CANCELLATION AND NO SHOW POLICY

We know that sometimes life is a juggling act and at some point you may need to cancel or move an appointment you've scheduled with us. Our request to you is that you provide at least 24 hours notice if this is the case. This will allow another person who is waiting for an appointment a chance to fill that time slot.

If you do not show up for your appointment without calling us to cancel, this will be considered a no-show. Patients who no-show two (2) or more times in a 12 month period may be dismissed from the practice and denied any future appointments.

If you cancel your appointment with less than 24 hours notification or fail to show up to your scheduled appointment, you will be subject to a $50.00 cancellation/no-show fee. This fee may be waived in special unavoidable circumstances, but only with management approval.

All questions about cancellation and no show fees should be directed to our front office staff.

Please sign that you have read, understand and agree to this Cancellation and No Show Policy.

_____

Patient Name (Please Print)

_____

Signature of Patient or Patient Representative

_____

Date

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PATIENT FINANCIAL POLICY

Our practice believes that a good physician/patient relationship is based upon understanding and good communication, especially when it comes to the cost of your care. As you may have noticed with your own coverage, insurance plans are becoming increasingly complex, and it is common for patients to be responsible for higher percentages of their medical bills than they have been in the past. Keeping this in mind, we do our best to provide an estimate for your treatment ahead of time so you can be prepared.

That said, we cannot always anticipate how your insurance will process your claims. Your insurance policy is an agreement between you and your insurance company, and any bill you may receive from our practice reflects what your insurance has determined you are responsible for. The balances on your account are ultimately your responsibility.

Our policy

Payment is due at the time of service. On the day of your visit, you will be expected to pay the estimate of what will not be covered by your insurance company. This may include your copay, coinsurance, and/or any unmet deductible amounts and payment for any non-covered services.

Accommodations

We understand that some patients may need more flexibility in paying for their medical care. We do offer payment plans, but any such arrangements must be made *prior* to your appointment. To take advantage of this option, we require that you keep a credit or debit card on file, and a minimum payment will be required at the time of service.

Flexible payment options

We accept VISA, MasterCard, Discover, CareCredit, cash, and personal checks. You may also make online payments directly from our website at www.northerninstride.com.

Please note

- Past due accounts are subject to collection proceedings. All costs incurred (including, but not limited to collection fees, attorney fees and court fees) will be your responsibility, in addition to the balance due at this office.
- You will be responsible for any charges your insurance may deny, including if you neglect to inform the office of a change in your insurance coverage.
- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

If you have any questions regarding our financial policy, please address them with our front office staff.

Printed Name of Patient/Responsible Party:_____ Date: _____

Signature of Patient/Responsible Party: _____ Date: _____