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
Cancer	Y	N
Diabetes	Y	N
Fibromyalgia	Y	N
Gout	Y	N
High Blood Pressure	Y	N
Neuropathy	Y	N

If you are diabetic, do you take Insulin? *Yes* | *No*

Last glucose reading: _____

Last A1C Level: _____

Other conditions: _____

_____

_____

_____

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?

_____

_____

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

FINANCIAL POLICY

Payment is due at the time of service. Copays will be collected at check-in. If you have an unmet deductible, we will collect 60% of the charges being sent to your insurance. After claims have been processed, any amounts you may have overpaid can be used as a credit toward future visits or refunded directly to you. If your up-front payment does not cover all services, you will receive a bill for any additional amounts your insurance has determined you are responsible for.

Discounts available

Our practice has established a single fee schedule that applies to all patients for each service provided. You may be entitled to a discount under the following circumstances:

- If we are in network with your health insurance plan
- If you are uninsured and being treated as a self-pay patient
- If you are taking advantage of our Cash Discount program
- Patients who have extreme hardship or other special circumstances may submit a written request to management to be offered a discount for a limited period of time as determined by the practice.

As of 1/1/2024, our office will be unable to extend any type of discounts other than those listed above.

Please note

- Past due accounts are subject to collections 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 have neglected to inform our 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.

CANCELLATION/NO-SHOW POLICY

If you fail to show up to your scheduled appointment or if you cancel with less than 24 hours notice to the practice, you will be subject to a $50.00 no-show fee, which is to be paid prior to your next scheduled visit. This fee may be waived in special unavoidable circumstances with management approval. 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.

I have read and understand both the financial policy and the cancellation/ no-show policy.

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

Signature of Patient/Responsible Party: _____ **Date:** _____