PATIENT INFORMATION

Date_____

Name_____ Social Security #_____

Date of Birth _____ Age _____ Sex: Male Female

Home Address_____

City _____State_____ Zip_____

Mailing/Billing Address (if different from above) _____

City _____State_____ Zip_____

Email Address _____

Phone: Home _____ Work _____ Cell_____

Phone Preference: Home Work Cell **Marital Status**: S M D Sep W

Race: (circle one) White/Caucasian American Indian/Alaska Native Asian
Black/African American Native Hawaiian/ Pacific Islander Other
Hispanic/Latino More Than One Race Refuse to Report

Preferred Language: English Other _____

Employment: (please circle) Retired Sits at job Stands at job Stands and walks at job

Occupation _____ Employer _____

Employer's Address _____

Primary Doctor _____ Date of last visit _____

Pharmacy _____ Location _____

Mail in Pharmacy _____

In case of **emergency**, who should be notified? _____

Phone _____ Relationship _____

Name of **insured person** (if other than patient) _____

Date of Birth _____ Relationship to patient _____ Phone _____

Address (if different) _____

Employed by: _____ Work# _____

Person responsible for bill (if other than patient): Name: _____

Relationship to patient: _____ Phone number: _____

Mailing/Billing Address _____

City _____State _____ Zip _____

What problem are you having today? _____

How long have you had this problem? _____

Have your ever had treatment in the past for this problem? Yes No

If yes, explain: _____

Are you allergic to: (circle all that apply) Lidocaine Codeine Tape Penicillin Aspirin Cortisone Betadine Latex Sulfa Other _____

Are you **Diabetic**? Yes No If yes, do you take insulin? Yes No If yes, number of years _____

Name of Medication	Dose (MG)	Directions for use	What do you take this medicine for?

Weight: _____ Height:_____ Shoe Size_____

List Past Surgeries: _____

_____

_____

Have you seen a Podiatrist before? Yes No If yes, List Past Foot Surgeries: _____

_____

List Past Foot Conditions: _____

_____

Have you ever been treated for or had a problem with any of the following: (please circle) Anemia Arthritis Asthma Bladder Cancer Circulation Frequent Infections Gout Healing High Blood Pressure HIV AIDS Intestines Kidneys Liver Lungs Neurological Disorders Rheumatic Fever Skin Stomach Ulcer Tuberculosis Unexplained Weight Loss Hepatitis B Hepatitis C

Do you have any Artificial Joints? Yes No If yes, explain:_____

Do you have a Heart Valve Implant? Yes No

Chart # _____

Family History:

Father - Living or Deceased Age _____ Cause of Death _____

Mother - Living or Deceased Age _____ Cause of Death _____

Do you use tobacco products? Yes No If yes, what type? Cigarettes How many packs a day? _____
Chewing tobacco Cigars Snuff

Do you drink Alcohol or Beer? Yes No If yes, please circle usage: Socially
Light Usage (1-2 per week) Moderate (1-2 per day) Heavy (more than 2 daily)

HIPPA Privacy Compliance

Please list the family members or other persons, if any, whom we may inform about your general medical condition, your diagnosis (including treatment, payment and health care):

Name: _____ Relationship to patient: _____ Phone #: _____

_____ _____ Phone #: _____

_____ _____ Phone #: _____

May we leave appointment reminders on your answering machine or voice mail?
Yes _____ No _____ *I am fully aware that a cell phone is not a secure and private line.

When you provide us with a wireless telephone or land line number you are giving us your prior express consent to call that number.

InStride Carolina Foot Care will use electronic sources i.e., telephone, Internet and fax to transmit health information for treatment and billing purposes.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay for treatment at the time services are rendered unless other arrangements are made with our financial secretary.

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release by mail, e-mail, fax, telephone or electronically as necessary all information necessary to secure payment of benefits and I hereby assign all insurance benefits to InStride Carolina Foot Care Associates, PLLC. I authorize the use of this signature on all insurance submissions.

I do acknowledge receipt of the Notice of Privacy Practices of InStride Carolina Foot Care Associates, PLLC. This signature also gives my permission for treatment and medication history by Dr. Terry Ann Donovan and/or Dr. William J. O'Neill.

_____ Date_____
Signature of Patient or Guardian (if patient is under 18 years)
(I certify that to the best of my knowledge all of the information listed above is correct.