InStride Crystal Coast Podiatry

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PATIENT INFORMATION

Full Legal Name: _____ Date: _____

Mailing Address: _____ City: _____ Zip: _____

Email: _____ Do you want online access to your medical records? _____

Home Phone: _____ Cell Phone: _____ SSN: _____

Date of Birth: _____ Age: _____ Sex: __ M __F Marital Status: M ___S ___ W __ D __Sep__

Referred By: _____ Personal Physician _____

Patient's Employer: _____ Position: _____

Business Address: _____

Spouse's Name: _____ Spouse's Date of Birth: _____

Spouse's Employer: _____ Spouse's Work Phone: _____

PERSON RESPONSIBLE FOR BILL

(IF OTHER THAN ABOVE)

Full Legal Name: _____ Relationship: _____

Address: _____

Phone: _____ DOB _____

Employer: _____ Position: _____

Business Address: _____

"We collect copays and deductibles at the time of service "

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Address: _____

Phone Number: _____ Secondary Phone: _____

FINANCIAL POLICY

I hereby authorize the physicians of InStride Crystal Coast Podiatry to release medical information including my diagnosis, medical history, and other medical material contained within those records to any referring physician, hospital, laboratories, therapist, and employers(is applicable), as deemed necessary. I also authorize the release of information necessary for processing my insurance, liability, Workers Compensation, or litigation claims, I authorize payment of benefits, where applicable, directly to these physicians otherwise payable to me for these services. I have has an opportunity to review the payment policy of InStride Crystal Coast Podiatry. I agree to the terms of the policy, and accept the responsibility that payments is ultimately my obligation, should I not stay within the parameters of my insurance plan, Payments is expected when the services are provided for any unauthorized services, co-insurances, co-pays, non-covered services, or self-pay accounts unless prior arrangements have been made.

_____

PATIENT OR GUARANTOR SIGNATURE **DATE**

3109 Trent Road
New Bern, NC 28562
Phone: 252.638.4700
Fax: 252.638.5766

www.crystalcoastpodiatry.com • www.instridefoot.com

GENERAL INFORMATION

Describe your foot pain: ____ Sharp ____ Shooting ____ Burning ____ Throbbing ____ Aching

Location of Pain and which foot: _____

How long has it been bothering you? _____ Days _____ Weeks _____ Years

List previous foot and/or ankle problems: _____

List previous surgical procedures done on your foot and/or ankle: _____

Shoe Size: _____ Shoe width: _____

MEDICAL INFORMATION

(THIS INFORMATION IS IMPORTANT FOR OUR RECORDS AND YOUR HEALTH)

Do you have Diabetes?: ☐ YES ☐ NO Number of years: _____ If yes, do you take insulin? ☐ YES ☐ NO

List serious illnesses: _____

List previous surgeries: _____

_____

Are you under a Physician's care? ☐ YES ☐ NO If yes, for what condition? _____

Primary Care Physician: _____ Date you last saw this Doctor: _____

May we contact your Physician about your health? ☐ YES ☐ NO

Are you allergic to any medications or substances? ☐ YES ☐ NO If yes, please list: _____

List the medications you take regularly, with dosages: _____

_____

Name of Pharmacy: _____

Are you or could you be pregnant? ☐ YES ☐ NO

Review of Systems:

Please indicate any symptoms you have experienced in the past 12 months:

CARDIAC:
- ☐ Shortness of Breath
- ☐ Chest Pains
- ☐ Irregular Heart Beat

GASTROINTESTINAL:
- ☐ Difficulty Swallowing
- ☐ Tooth Abscess/Infection
- ☐ Indigestion/Heartburn
- ☐ Nausea/Vomiting
- ☐ Diarrhea
- ☐ Blood in Stools
- ☐ Stomach Pains

GENERAL:
- ☐ Common Cold
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Fever/Chills
- ☐ Night Sweats
- ☐ Multiple Joint Pains

NEUROLOGIC:
- ☐ Blurred Vision
- ☐ Migraines
- ☐ Headaches
- ☐ Numbness/Tingling
- ☐ Dizziness
- ☐ Depression

RESPIRATORY:
- ☐ Wheezing
- ☐ Shortness of Breath
- ☐ Chronic Cough

VASCULAR:
- ☐ Bleeding Disorder
- ☐ Blood Clots
- ☐ Swollen Legs
- ☐ Difficulty Stopping Bleeding after Surgery

Past Medical History:

Have you ever been treated for or been informed by a physician that you have any problems with the following?

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Pressure Problems
- ☐ Cancer
- ☐ Circulatory Disorder
- ☐ Depression
- ☐ Drug Abuse
- ☐ Epilepsy
- ☐ Frequent Infections
- ☐ Gout
- ☐ Healing Problems
- ☐ Heart
- ☐ Hepatitis
- ☐ Hormone Problems
- ☐ HIV / AIDS
- ☐ Intestinal Problems
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Neurological Disorder
- ☐ Polio
- ☐ Prolonged Bleeding
- ☐ Rheumatic Fever
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Unexplained Weight Loss
- ☐ Other, Explain

Do you have any surgically placed prosthesis? (heart valve, hip joint, etc.) ☐ YES ☐ NO

Do you smoke? ☐ YES ☐ NO Number of packs per day: _____ How long? _____

Have you smoked previously? ☐ YES ☐ NO

Do you drink alcohol or beer? ☐ YES ☐ NO ☐ Light usage (1-2 weekly) ☐ Moderate usage (1-2 daily) ☐ Heavy usage (2+ daily)

Employment: ☐ Sit at Job ☐ Stand at Job ☐ Stand and Walk at Job ☐ Retired

FAMILY HISTORY

Mother:	☐ Living	☐ Deceased	Cause of death: _____
Father:	☐ Living	☐ Deceased	Cause of death: _____
Brother:	☐ Living	☐ Deceased	Cause of death: _____
Sister:	☐ Living	☐ Deceased	Cause of death: _____

Is there a family (blood relative) history of:

- ☐ Arthritis
- ☐ Bleeding Disorder
- ☐ Bunions
- ☐ Circulation Problems in Legs or Feet
- ☐ Diabetes
- ☐ Flatfeet
- ☐ Hammertoes
- ☐ Heart Disease
- ☐ Neurological Disorder
- ☐ Stroke

_____

Signature Date