PATIENT INFORMATION

Full Legal Name:_____Preferred name:_____

Mailing Address:_____City:_____Zip:_____

Email:_____Do you want online access to your med records? ☐Yes ☐No

SSN: _____ Patient's Date of Birth:_____

Primary Phone:_____☐Cell ☐Home

2nd phone:_____ ☐Cell ☐Home

Sex: ☐Male ☐Female

Marital Status: ☐Married ☐Single ☐Widowed ☐Divorced ☐Separated ☐Domestic Partner

Employment status: ☐Employed Full-time ☐Employed Part-time ☐Retired ☐Student ☐Not Employed

Name & location of Personal Physician:_____

Spouse's name:_____Date of Birth:_____

Emergency Contact Name:_____

Phone:_____Relationship to patient:_____

Please tell us how you found Crystal Coast Podiatry:

☐Doctor (name)_____ ☐Family/Friend ☐Internet ☐Other_____

PERSON RESPONSIBLE FOR BILL

(If someone other than patient)

Full Legal Name:_____Relationship to patient:_____

Address:_____

Phone:_____ ☐Cell ☐Home Date of Birth:_____

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 (if 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 had 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 payment is ultimately my obligation, should I not stay within the parameters of my insurance plan. Payment is expected when the services are provided for any unauthorized services, co-insurances, copays, non-covered services, or self-pay accounts, unless prior arrangements have been made.

I understand that if I am unable to keep a scheduled appointment, I must give a minimum 24-hour notice, or I will be charged a $40 no-show fee.

Signature (Patient or Guarantor)_____Date:_____

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PATIENT NAME: _____ Date of birth:_____

What sort of problem you are having today?_____

Location of problem and which foot? _____

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

If you are having foot pain, would you describe it as: ☐Sharp ☐Shooting ☐Throbbing ☐Aching

List previous foot and/or ankle problems: _____

List previous foot and/or ankle surgical procedures:_____

MEDICAL INFORMATION

Please answer ALL questions! This information is VERY important for our records and your health!!

Do you have DIABETES? ☐YES ☐NO If yes, for how many years? _____ Do you take insulin? ☐YES ☐NO

List serious illnesses here: _____

List previous surgeries: _____

_____

Primary care physician:_____ Date last seen by this Dr. _____

Are you under a physician's care for any type of condition? ☐ YES ☐ NO If yes, what type of condition?_____

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

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

List the medications you take regularly, with dosages. (use the back of this paper If needed) _____

_____

Name & location of pharmacy: _____

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

Please indicate below any symptoms you have experienced in the **PAST 12 MONTHS:**

CARDIOVASCULAR:	GASTROINTESTINAL:	GENERAL:	NEUROLOGIC:	RESPIRATORY	VASCULAR:
☐Shortness of breath ☐Chest Pains ☐Irregular Heartbeat	☐Difficulty swallowing ☐Indigestion/heartburn ☐Nausea/vomiting ☐Diarrhea ☐Blood in Stools ☐Stomach Pains	☐Common cold ☐Weight Loss ☐Weight Gain ☐Fever/chills ☐Night Sweats ☐Multiple joint pains ☐Tooth abscess/infection	☐Blurred vision ☐Migraines ☐Headaches ☐Numbness/tingling ☐Dizziness ☐Depression	☐Wheezing ☐Shortness of Breath ☐Chronic Cough	☐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	☐Epilepsy	☐HIV / AIDS	☐Rheumatic Fever
☐Arthritis	☐Frequent infections	☐Intestinal problems	☐Stomach ulcers
☐Asthma	☐Gout	☐Kidney Disease	☐Stroke
☐Blood pressure problems	☐Healing problems	☐Liver Disease	☐Tuberculosis
☐Cancer	☐Heart problems	☐Lung Disease	☐Unexplained weight loss
☐Circulatory Disorders	☐Hepatitis	☐Neurological Disorder	☐Other, explain:
☐Depression	☐High cholesterol	☐Polio	
☐Drug Abuse	☐Hormone problems	☐Prolonged bleeding	

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? ☐YES ☐NO If yes, how often? ☐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:_____
Sibling 1 ☐Living ☐Deceased Cause of death:_____
Sibling 2 ☐Living ☐Deceased Cause of death:_____

Is there family (blood relative) history of: ☐Arthritis ☐Bunions ☐Hammertoes ☐Flat feet ☐ Circulation problems in legs or feet
☐Bleeding disorder ☐Neurological Disorder ☐Diabetes ☐Heart Disease ☐Stroke