InStride Piedmont Podiatry Associates

11 Mills Avenue
Greenville, SC 29605

700 North A. Street
Easley, SC 29640

PATIENT INFORMATION – PLEASE PRINT

Full Name ____
LAST FIRST MIDDLE

Mailing Address ____
STREET CITY STATE ZIP

Date of Birth ____/____/____ Age: ____ Social Security #: ________________________________

Home Phone (___) ___-____ Work Phone (___) ___-____ Email:________________________________

Marital Status: S M D W Sex: M____ F____ Height: ____ Weight: ____ Shoe Size: ____

Employment Status: Full Part Student Retired Employer: ________________________________

Emergency Contact: ________________________ Relation: ____________ Phone (___) ___-____

Pharmacy Name: ____________________ Address: ____________________ Phone (___) ___-____

RESPONSIBLE PARTY (*Fill out only if minor or insurance is in spouse's name.)*

Full Name ____ Relation _____________
LAST FIRST MIDDLE

Mailing Address ____
STREET CITY STATE ZIP

Date of Birth ____/____/____ Sex: M____ F____ Phone (___) ___-____ SSN________________

****Required by Federal Government****

Preferred Language ___________________________ **Sex**: M ____ F ____

Race: (circle) African American Alaska Native American Indian Asian White

Native Hawaiian Pacific Islander Other Race Declined to Specify

Ethnicity: (circle) Hispanic or Latino Not Hispanic or Latino Declined to specify

Smoking Status: (check) Current Every Day Smoker ___ Current Some Day Smoker___

Former Smoker___ Never Smoker___ Smoker (Status unknown)___ Unknown if ever smoked___

REQUIRED

Family Physician Full Name: ______________________________ Phone (____) ____-_____

Address____

Referring Physician Full Name: ____________________________ Phone (____) ____-_____

Address____

INSURANCE INFORMATION

Primary Insurance Name ____

Insured Name ________________________ Patient's Relationship to Insured: ___________________

Policy # _____________________________________ Group # ______________________________

Secondary Insurance Name ____

Insured Name ________________________ Patient's Relationship to Insured: ___________________

Policy # _____________________________________ Group # ______________________________

I hereby authorize payment to **INSTRIDE PIEDMONT PODIATRY ASSOCIATES,** a division of **NORTH CAROLINA PODIATRIC PHYSICIANS AND SURGEONS GROUP, PLLC.** of the benefits, including major medical insurance, if any, otherwise payable to me for their services. I understand that I am financially responsible for the charges whether or not covered by my insurance company. I certify that the above information is true and correct to the best of my knowledge.
I authorize the release to my insurance carriers any information to process any of my claims.
I authorize medical treatment from Piedmont Podiatry Associates, P.A. Unless this authorization is limited or revoked, I further consent to such treatment as is recommended by Piedmont Podiatry Associates, P.A. I understand that this authorization may be limited or revoked, in whole or in part, at any time either orally or in writing.

_______________________________________ _____/_____/_____

Patient's Signature (Parent, if patient is a minor) Date

PLEASE COMPLETE THE FOLLOWING INFORMATION

Name:______________________ DOB:____________ Height:______ Weight:______

What is your main purpose for todays visit? (Please indicate what your complaint feels like, what makes it better or worse and what you are concerned the problem may be.)

____

Please list any allergies that you may have:

____

____

Previous Surgeries:______________

____

____

Have you been in generally good health lately? Yes ___ No ___

Do you have any of the following?

Condition	Yes	No
Heart/circulation problems	Yes ___	No___
Arthritis	Yes ___	No ___
Asthma	Yes ___	No ___
Cancer	Yes ___	No ___
COPD	Yes ___	No ___
Depression/Anxiety	Yes ___	No ___
Diabetes	Yes ___	No ___
Fibromyalgia	Yes ___	No ___
Gerd	Yes ___	No ___
Gout	Yes ___	No ___
Headache	Yes ___	No ___
Hepatitis	Yes ___	No ___
Hypertension	Yes ___	No ___
Kidney, liver or lung disease	Yes ___	No ___
Back or neck pain	Yes ___	No ___
Neuropathy	Yes ___	No ___
Seizures	Yes ___	No ___
Sleep apnea	Yes ___	No ___
Stroke	Yes ___	No ___
Thyroid disease	Yes ___	No ___
Bleed or Bruise Easily	Yes ___	No ___
Joint Pain or Weakness	Yes ___	No ___
Memory Loss or Confusion	Yes ___	No ___
Frequent Cough	Yes ___	No ___
Glasses or Contacts	Yes ___	No ___

Please let us know if you have any family history and who has/had the problem?

____

____

____

____

____

Shoe Size: ___________

Marital Status:________________ Number of Children: ____________

Are you employed?____________ Place of Employment:____________________

Do you smoke or have you ever smoked? _____ If so, how much per day? _____Date Stopped:_____

Do you drink caffeine? ______________ If so, how much a day?________________

Please list all medications:

____

____