PATIENT REGISTRATION FORM

(PLEASE FILL OUT COMPLETELY)

****

LAST NAME: _____ FIRST NAME: _____ MI: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE #'S: HOME: (____) _____ - _____ WORK: (____) _____ - _____

CELL: (_____) _____ - _____ OTHER: (_____) _____ - _____

E-MAIL ADDRESS: _____ FAX: (_____) _____ - _____

BIRTHDATE: ____ / ____ /____ AGE: _____ SOCIAL SECURITY #: _____

MARITAL STATUS: (CIRCLE) MARRIED SINGLE WIDOWED SEPARATED DIVORCED

ARE YOU A STUDENT? YES: ____ NO: ____ IF YES: FULL TIME: ___ PART TIME: ____

EMPLOYER NAME: _____ RETIRED: YES: ____ NO: ____

MEDICAL DOCTOR'S NAME: _____ CITY/CLINIC: _____

HOW WERE YOU REFERRED TO OUR OFFICE?

DOCTOR☐ PATIENT☐ YELLOW PAGES☐ DIRECTORY☐ AD☐ OTHER: _____

NAME: _____

EMERGENCY CONTACT: NAME: _____

CONTACT #: _____ RELATIONSHIP TO PATIENT: _____

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 choose, and understand the Notice. INITIAL:_____

DATE: _____ /_____ /_____ **PATIENT SIGNATURE**: _____

PLEASE HAVE INSURANCE CARDS AVAILABLE SO WE CAN MAKE COPIES.

IT IS YOUR RESPONSIBILITY TO NOTIFY THE OFFICE STAFF IF YOUR INSURANCE OR ANY OF YOUR PERSONAL INFORMATION CHANGES.

InStride Chapel Hill Foot & Ankle Associates

Patient Name			
Patient Date of Birth		**Preferred Pharmacy**	
Date			
Chief Complaint / Reason for Visit			
Name of Primary Care Physician (PCP)		**Date of Last Visit with PCP**	
Shoe Size and Width		**Hemoglobin A1c**	

PATIENT - PAST MEDICAL HISTORY (Circle all that apply)

GENERAL HISTORY	Cancer (Type?)		MRSA	HIV	Hospice Care	COVID-19
CARDIOVASCULAR DISEASES	Heart Disease	Atrial Fibrillation	Taking Anticoagulants	Lymphedema	Coronary Artery Disease	Peripheral Artery Disease
	DVT Lower Extremity	Hyperlipidemia	Hypertension	Transient Ischemic Attack	Cerebral Infarction	
PULMONORY DISEASES	Asthma	COPD	Pulmonary Disease	Dependent on Supplemental Oxygen		
NEUROLOGIC DISEASES	Peripheral Neuropathy	Parkinson's	Dementia	Foot Drop		
ORTHOPEDIC PROBLEMS	Arthritic joints	Rheumatoid Arthritis	Psoriatic Arthritis	Radiculopathy	Osteoporosis	Amputations
	Lower Back Pain	Joint Replacement				
GENITOURINARY DISEASES	Renal Disease	Renal Dialysis				
GASTROINTESTINAL DISEASES	Hepatic Disorder	Hepatitis(A B C)	Esophageal Reflux	Gastric Ulcer	Crohn's Disease	Irritable Bowel Syndrome (IBS)
METABOLIC DISEASES	Diabetes Mellitus	Thyroid Disease	Pre-Diabetes	Gout		
DERMATOLOGIC DISEASES	Ulcer on Foot	Skin Disorder	Onychomycosis	Malignant Melanoma of Skin	Malignant Neoplasm of Skin	Psoriasis
PSYCHIATRIC DISORDERS	Dementia	Alzheimer's Disease	Cognitive Functioning Diminished		Anxiety	Depression

ALLERGIES TO MEDICATION / TAPE /FOOD (NAME AND REACTION)

MEDICATIONS (NAME AND DOSE)

InStride Chapel Hill Foot & Ankle Associates

PAST SURGICAL HISTORY

SOCIAL HISTORY

TOBACCO USE	Never Smoked	Previous History of Smoking	Current Everyday Smoker	Current Some	Packs Per Day	
ALCOHOL USE	Never Drank Alcohol	Alcohol Use	Drinking in Moderation (2 drinks or fewer/day)		Recovering Alcoholic	
EXERCISE AND ACTIVITY	Exercise Regulary					
HOME LIFE	Live Alone	Live with Spouse	Live with Significant Other		Live with Parents	Live in Nursing Home
WORK STATUS	Working Full Time	Working Part-Time	Retired	Physically Disabled		

FAMILY HISTORY

GENERAL HISTORY	Unobtainable	Coagulation Defects				
GRANDPARENTS	Diabetes Mellitus	Renal Disorder	Hypertension	Hyperlipidemia	Heart Disease	Arthritis
	Family History of Cancer		Coagulation Defects			
FATHER	Diabetes Mellitus	Renal Disorder	Hypertension	Hyperlipidemia	Heart Disease	Arthritis
	Family History of Cancer		Coagulation Defects		Father Deceased	
MOTHER	Diabetes Mellitus	Renal Disorder	Hypertension	Hyperlipidemia	Heart Disease	Arthritis
	Family History of Cancer		Coagulation Defects		Mother Deceased	
SIBLINGS	Diabetes Mellitus	Renal Disorder	Hypertension	Hyperlipidemia	Heart Disease	Arthritis
	Family History of Cancer		Coagulation Defects			

ADDITIONAL INFORMATION

Patient Name: Patient Date of Birth:

CHAPEL HILL FOOT AND ANKLE ASSOC., P.A.

1506 E. Franklin Street
Suite 104
Chapel Hill, NC 27514

Phone: (919)960-8858
Fax: (919)960-2882

NOTICE TO OUR PATIENTS

Although you have obtained the proper authorization from your primary care physician, if your managed care insurance company determines that a particular service is "**not medically necessary**" , the company will not pay for the visit and the patient is responsible for any amount due on the day that the service is rendered.

Services that are considered non-covered may include the following:

Trimming of toenails, corns, and calluses
(this includes routine foot care for the diabetic patient that requests nails, corns and calluses trimmed.)

The treatment of flat feet, orthotics, arch supports, molded shoes, removable casts, and other foot care items including padding supplies.

For a complete listing, please consult your member booklet, or telephone your insurance company.

BENEFICIARY AGREEMENT:
I have been notified by this office that my managed care insurance company may deny payment for the services received. I agree to be personally responsible for payment on the day that the service is given.

_____ _____

PATIENT SIGNATURE DATE SIGNED

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

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 choose) and understand the Notice.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature