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