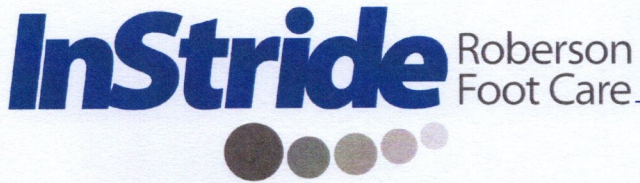


Patient Name: _____ Patient DOB: _____

| PATIENT INFORMATION SHEET | | | | |
|---|--|--|---|--|
| Referred By: If you were referred to us by your physician, please write his/her name below: | | | | |
| <input type="checkbox"/> Sign | <input type="checkbox"/> Website | <input type="checkbox"/> Doctor | <input type="checkbox"/> Insurance | <input type="checkbox"/> Family/Friend |
| Other: _____ | | Referring Doctor: _____ | | |
| First Name: _____ | Last Name: _____ | Middle Initial: _____ | | |
| Address: _____ | | City/State/Zip: _____ | | |
| Email Address: _____ | | Date of Birth: _____ | | |
| Home Phone #: _____ | | Cell Phone #: _____ | | |
| Gender: _____ | | SS No.: _____ | | |
| Employer: _____ | | Marital Status: _____ | | |
| Pharmacy: _____ | | Pharmacy Phone #: _____ | | |
| Emergency Contact: _____ | | City/State/Zip: _____ | | |
| Reason for Visit / Chief Complaint: _____ | | | | |
| Primary Care Doctor: _____ | | | Date of Last Visit to PCP: _____ | |
| INSURANCE INFORMATION (please present insurance card at check in) | | | | |
| Insurance Co Name: _____ | | Insured's Name: _____ | | |
| Insurance ID Number: _____ | | Member Number: _____ | | |
| Group Number/Name: _____ | | Insured's DOB: _____ | | |
| PATIENT - PAST MEDICAL HISTORY | | | | |
| <input type="checkbox"/> Tested Positive for Covid-19 | <input type="checkbox"/> Swelling in Legs | <input type="checkbox"/> Received Covid-19 Vaccine | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hospice Care |
| <input type="checkbox"/> Cancer (Type) _____ | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> MRSA | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> COPD | <input type="checkbox"/> Take Blood Thinner | <input type="checkbox"/> Restless Legs | <input type="checkbox"/> Afib |
| <input type="checkbox"/> Blood Clot Leg | <input type="checkbox"/> Tremors | <input type="checkbox"/> Stroke | <input type="checkbox"/> Use Cane | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Use Oxygen | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Use Walker |
| <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Kidney Disease Stage | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Gastric Ulcer | <input type="checkbox"/> Psoriatic Arthritis | <input type="checkbox"/> Acid Reflux | |
| <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Electric Scooter | <input type="checkbox"/> Alzheimer's Disease | |
| <input type="checkbox"/> Hepatitis (A B C) | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Diabetic | |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Foot Ulcer | <input type="checkbox"/> HIV | <input type="checkbox"/> Psoriasis | |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Depression | | | |
| SOCIAL HISTORY | | | | |
| Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other | | | | |
| Use of Tobacco: | <input type="checkbox"/> Current Everyday | <input type="checkbox"/> Never Smoker | <input type="checkbox"/> Former Smoker | Tobacco amount Per Day _____ |
| Use of Drugs: | <input type="checkbox"/> Use Illegal Drugs | <input type="checkbox"/> Never Used Drugs | <input type="checkbox"/> Recovering from Drug Addiction | |
| Alcohol Use: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Occasionally | If Yes, how often: Drinks per day: _____ |
| Exercise & Activity | <input type="checkbox"/> Exercise Regularly | <input type="checkbox"/> Not Exercising Regularly | | <input type="checkbox"/> Standing Required for Work |
| Home Life: | <input type="checkbox"/> Live Alone | <input type="checkbox"/> Live with Spouse | <input type="checkbox"/> Live with Parents | <input type="checkbox"/> Live with Significant Other/Caretaker |
| | <input type="checkbox"/> Lives in Nursing Home | | | |
| Work Status: | <input type="checkbox"/> Working Full Time | <input type="checkbox"/> Retired | <input type="checkbox"/> Working Part Time | <input type="checkbox"/> Physically Disabled |



Ainsley Roberson Rusevlyan, DPM

114 Avon Avenue | Washington, NC 27889

Phone: 252-946-1181

Fax: 252-946-2309

RELEASE OF MEDICAL INFORMATION

PLEASE PRINT YOUR NAME: _____

BY SIGNING BELOW, I AUTHORIZE INSTRIDE ROBERSON FOOT CARE TO RELEASE MY MEDICAL AND BILLING INFORMATION TO:

RELATIONSHIP: NAME OF DESIGNATED PERSON
SPOUSE [] YES [] NO
CHILDREN [] YES [] NO
IN-LAWS [] YES [] NO
CAREGIVERS [] YES [] NO
PARENTS [] YES [] NO
OTHERS [] YES [] NO

PATIENT SIGNATURE _____ DATE _____
PARENT SIGNATURE _____ DATE _____

We ask that if you have any change in this request, that you please inform the receptionist.

INSTRIDE ROBERSON FOOT CARE MAY LEAVE APPOINTMENT INFORMATION ON MY VOICE MAIL:

HOME [] YES [] NO
WORK [] YES [] NO
RELATIVE [] YES [] NO

PATIENT SIGNATURE _____ DATE _____

I AUTHORIZE THE FOLLOWING TO PICK UP PRESCRIPTIONS, X-RAYS, ETC.

RELATIONSHIP: NAME OF DESIGNATED PERSON
SPOUSE [] YES [] NO
RELATIVE [] YES [] NO
CAREGIVER [] YES [] NO

PATIENT SIGNATURE _____ DATE _____

I UNDERSTAND THAT INSTRIDE ROBERSON FOOT CARE WILL ASK FOR IDENTIFICATION OF THE PERSON PICKING UP PATIENT MEDICAL INFORMATION OR PRODUCTS

NOTICE OF PRIVACY ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

Patient Name or Legal Guardian: _____

Signature: _____

Date: _____

PRACTICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment of the Notice of Privacy Practices Acknowledgment but was unable to do so as documented below:

| | | |
|-------|-----------|---------|
| Date: | Initials: | Reason: |
|-------|-----------|---------|

Welcome to our New Patients

Our practice is a division of the InStride Foot & Ankle Specialists, PLLC. We have divisions across North and South Carolina, and we operate under one tax ID number. As such, if you have seen any of the following physicians in the past three years, we need to know so that we will not file a new patient code for your visit today. Since the insurance carriers look at us as one large practice, if you have been seen at any of the following divisions, you will not be considered a new patient in our practice. Visits prior to 2017 do not need to be disclosed.

Please review the names of the divisions and podiatrists below and indicate if you have been seen at any of these divisions by putting a V on the line to the left of the practice name. Thank you for disclosing this information to us – it will allow us to be in compliance with nationally mandated correct coding initiatives.

| | DIVISION | PODIATRIST |
|--|---|---|
| | Alta Ridge Foot Specialists (Resigned from Group 1/1/20) | Robert van Brederode, William Broyles, Thomas Verla |
| | Ankle & Foot Center of Charlotte (Resigned from group 7/1/2017) | Scott Basinger |
| | Brunswick Foot & Ankle Surgery, PA | Joseph Kibler |
| | Capital Foot and Ankle Centers | Eldon Peters (eff: 10/1/2018) |
| | Carmel Foot Specialists (Resigned from group 1/1/20) | Barbara Kaiser, Richard Lind, Richard Miller, Kevin Molan, Tori Simmons-Lewis |
| | Carolina Foot & Ankle Health Center | Millicent Brown |
| | Carolina Foot Care Associates, PLLC | Ashma Davidson, Terry Donovan (ret 1/1/18), William O'Neill |
| | Carolina Podiatry Group | Brandon Percival, Julie Percival, William Harris, Katlin Jackson (eff:7/1/19), Robert Ezewuiro (eff:8/15/19) |
| | Central Carolina Foot & Ankle Associates | Melissa Hill, Gary Liao, Alan Sotelo |
| | Chapel Hill Foot & Ankle Associates, P.A. | Jane Andersen, Alan Bocko, Katherine Williams |
| | Charlotte Foot & Ankle Specialists, PLLC (resigned from group 8/1/2017) | Kristine Strauss |
| | Coastal Carolina Foot & Ankle | Thomas Hagan, Tyler Hagan |
| | Coastal Carolina Foot & Ankle Associates | Jeffrey Pupp(ret. 12/31/2019), Kevin Bachman (eff: 1/1/2019), Derek Pantiel |
| | Comprehensive Foot & Ankle Center, P.A. | Zack Nellas |
| | Crystal Coast Podiatry | Thomas Bobrowski |
| | Family Foot & Ankle Center, P.A. | Patrick Dougherty, Doug Smith |
| | Family Foot Care | Kevin McDonald, Neil Younce (eff: 10/1/2019), Erin Younce (eff: 12/19/2019) |
| | Foot & Ankle Center of Durham | Eric Simmons |
| | Foot & Ankle of the Carolinas, PLLC | Eric Ward, Blaise Woeste |
| | Gaston Foot & Ankle Associates, P.A. (Resigned from Group 12/1/19) | David Kirilin, Ryan Meredith, Wagner Santiago, Randell Contento |
| | Greensboro Podiatry Associates, P.A. | Martha Ajlouny, N'Tuma Jah (resigned 12/21/17), Jonathan Simpson (eff: 1/1/18) term 5/10/18 |
| | Hendersonville Podiatry | Russ Barone(ret. 2/2/18), Pam Stover |
| | James Mazur, D.P.M., P.A. | James Mazur, Erin Younce (eff: 12/19/2019) |
| | Kinston Podiatry | Dale Delaney |
| | Matthews Foot Care | Brian Killian, Kevin Killian, David Ellenbogen(termed 10/23/19), Wesley Jackson (eff: 7/1/19) |
| | Mt. Airy Foot & Ankle Center, PLLC | Jim Shipley, David Collard, Walter Falardeau, Thurmond Sicheloff termed 10/23/2018), Jeffrey Hunter (eff: 7/1/19) |
| | Myers Podiatric Clinic | William Myers |
| | Piedmont Foot & Ankle Clinic (Terming from Group 2/1/20) | Rick Hauser, Rob Lenfestey (ret.), Jason Nolan, Joel Kelly, Elizabeth Bass Daughtry, Jacob Panici, Brian Futrell (eff:3/1/18) |
| | Piedmont Podiatry Associates | Subodh Choudhary, Nicholas Canoutas, Cassandra Pike, Sarah Fitzgerald |
| | Queen City Foot & Ankle Specialists, P.C. | Roxanne Burgess, Alison Garten(termed 11/6/19), Wesley Jackson (eff: 7/1/19) |
| | Raleigh Foot & Ankle (Resigned from Group 1/1/2018) | Alan Boehm, Robert Hatcher, Jordan Meyers, Kirk Woelffer |
| | Roberson Foot Care, PC | Ainsley Rusevlyan (eff: 2/1/2019) |
| | Ryan Foot & Ankle Clinic | David Garchar, Jeff Glaser, Michael Ryan, Scott Whitman, Matthew Borns, Bradley Lind (eff:7/23/19) |
| | Salem Foot Care | Scott Matthews |
| | Summit Podiatry | Derek Pantiel, Kevin Bachman |
| | Upstate Foot Care | Hans Blaakman |
| | Wake Foot & Ankle Center | Mike Hodos, Jim Judge |
| | Wilson Podiatry Associates, PA | Kendall Blackwell |

_____ I attest that I have been seen in the above indicated division of the InStride since 01/01/2017.

_____ I attest that to my best recollection, I have not been seen by any of the above divisions/physicians since 01/01/2017.

Signature of Patient: _____ Date: _____