FOOT AND ANKLE CENTER OF DURHAM

A division of InStride Foot & Ankle Specialists

Date:_____

Patient Demographics

First Name:_____M.I.:____ Last Name:_____Preferred Name:_____

Address:_____Apt/Unit#:____ City:_____State: _____Zip:_____

Email address: _____ **SSN**_____

Date of Birth **(MM/DD/YYYY):**_____ Living in Nursing Home or Facility? ☐ Yes ☐No

Phone: (H) _____ (M) _____ (O) _____

Reminder preference: ☐Email ☐ Text ☐ Phone Referred by: ☐PCP ☐Website ☐ Other: _____

Gender: ☐Male ☐Female Race: ☐White/Caucasian ☐Black/African American ☐Hispanic ☐Asian ☐Other:_____

Marital Status: ☐Single ☐Married ☐ Divorced ☐ Widowed Ethnicity: ☐ Hispanic/Latino ☐Not Hispanic/Latino

Primary Care Physician (PCP): _____ Last office visit (MM/YYYY):_____

Insurance card holder: _____ Date of Birth: _____

Who is responsible for patient's bills, if not the patient? ☐ Patient is responsible ☐ Other person (list below):
Name:_____Phone: (___) _____ Relationship to patient:_____

Authorization for Release of Information to Family and/or Friends *(Optional* Section)

I hereby authorize FAD to discuss my medical care and release my confidential protected health information (PHI) to:

☐Emergency Contact:_____ Phone:_____
Relationship to patient: Information to be released: ☐Any or ☐ As follows:_____

☐Primary Care Provider:_____ Phone: _____
Approximate date of last visit: Information to be released: ☐Any or ☐As follows:_____

☐Other: _____ Phone:_____
Relationship to patient: Information to be released: ☐Any or ☐As follows:_____

Rights of the patient:

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect a copy of the protected health information to be disclosed as described in this document by sending written notification to **Foot and Ankle Center of Durham, 3811 N. Roxboro St, Durham, NC 27704.** I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward from the date on the revocation.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization.

This authorization shall be in force and effect until revoked by the patient or representative signing the authorization on behalf of the patient.

_____ _____

Patient Signature, or Parent or Authorized Representative Signature (Representative must provide proof of authority over patient) Date

I acknowledge that I was offered, or provided, a copy of the Notice of Privacy Practice and that I have read (or had the opportunity to read if I so chose) and understand this Notice.

_____ _____

Patient Signature, or Parent or Authorized Representative Signature Date