# **Billie A. Bondar, DPM**-Intake Form

Name:_____DOB_____

## Demographics

Preferred name:_____

Gender: ☐Male ☐Female ☐Other_____ Gender at birth: ☐Male ☐Female

Marital Status:_____ SS#_____

Preferred phone_____☐home ☐cell ☐other Addition phone#_____

Email address: _____

Can we send text and/or email notifications ☐YES ☐NO

Mailing Address:_____City_____State_____Zip_____

Employer:_____Occupation:_____

Emergency Contact:_____Phone:_____Relation_____

How did you find out about our practice: _____

Preferred Pharmacy:_____ City:_____

Primary Care Provider:_____ Date Last Seen_____

Referring Provider: _____ Date Last Seen _____

## Insurance Information

*Primary Insurance_____ policy Holder: ☐SELF ☐Spouse ☐Parent ☐Other

Subscriber name (if other than self)_____ DOB_____Gender:_____

ID/Policy #: _____ Group #_____

*Secondary Insurance_____ policy Holder: ☐SELF ☐Spouse ☐Parent ☐Other

Subscriber name (if other than self)_____ DOB_____ Gender:_____

ID/Policy #: _____ Group #_____

What is the reason for your visit today? _____

How long has it bothered you?_____days/weeks/months

What treatments have you tried? _____ Have they been effective? ☐YES ☐NO

On a scale of 1-10 what is your level of pain? ____/10

Pain quality? ☐Burning ☐Constant ☐dull ☐ sharp ☐shooting ☐throbbing ☐tingling other:_____

Are you Diabetic? ☐YES ☐NO Who treats your Diabetes?_____ Date last seen_____

How long have you been diabetic? _____ What is your A1C?_____

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Name:_____DOB_____

**Vitals**
Blood Pressure: _____
Height: _____
Weight: _____
Shoe Size: _____

**Medical history:** ☐Alcoholism (past/current) ☐Anemia ☐Anxiety ☐Arthritis ☐Asthma
☐Back problems ☐Mental illness (specify)_____☐Cancer(specify)_____ ☐COPD
☐High Cholesterol ☐Dementia ☐Depression ☐Dermatitis ☐Diabetes (type I or type II)
☐Edema ☐GERD ☐Gout ☐Heart Disease ☐HIV ☐Headaches ☐Hepatitis
☐High Blood Pressure ☐Kidney Disease ☐Migraine ☐Neuropathy ☐Osteoporosis
☐Sleep Apnea ☐Stomach or bowel disorder ☐Stroke ☐TB ☐Thyroid Disease
☐Vascular disorder ☐OTHER_____ ☐NONE

Have you seen Podiatrist in past? ☐No ☐Yes who?_____when? _____

**Family History (please specify relationship) ☐None ☐Unknown**

*We are only looking for 1st degree relatives, Parent/Siblings/Children-**please specify relation***

☐Circulatory problems _____ ☐Dementia_____
☐Alzheimer's _____ ☐Depression _____
☐Anxiety_____ ☐Diabetes _____
☐Arthritis_____ ☐High blood pressure_____
☐Asthma_____ ☐Stroke_____
☐Cancer _____ ☐Thyroid Disease_____
☐Heart Disease_____ ☐Blood Clot_____
☐OTHER_____

**MEDICATIONS**
☐No known medications
Name/Dose:_____
Name/Dose:_____
Name/Dose:_____
Name/Dose:_____
Name/Dose:_____
Name/Dose:_____
Name/Dose:_____
Name/Dose:_____
Name/Dose:_____
Name/Dose:_____

**ALLERGIES**
☐No known Drug allergies
Name:_____
Name:_____
Name:_____
Name:_____
Name:_____
Name:_____
Name:_____
Name:_____
Name:_____
Name:_____

**Use back of form for additional space**

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**Surgical History** ☐NONE ☐Appendectomy ☐C-section ☐ Bypass ☐Cataract
☐gall bladder removal ☐Pacemaker ☐Artificial heart valve ☐Heart
☐Joint replacement (specify)_____
☐Foot/Ankle surgeries_____
☐OTHER_____

## Social History

Do you Smoke ☐YES TYPE: ☐Cigarette ☐Cigar ☐Vape ☐**FORMER** Smoker ☐**NEVER** smoker
If yes, How many/often per day?_____

Do you Drink? ☐YES ☐NO If yes, ☐Heavy ☐Light ☐Social ☐Rarely TYPE: ☐Beer ☐Wine ☐Hard Alcohol

Do you use illegal or street drugs? ☐YES ☐NO If yes please describe:
_____
Do you have a substance abuse problem? ☐YES ☐Past ☐NO
IF YES please describe:_____

**Review of Systems** (please check box if you currently have these symptoms)
**Cardiovascular** ☐Leg pain when walking ☐ fever ☐chest pain/pressure ☐leg swelling ☐cold hands/feet ☐fainting ☐palpitations ☐vascular disease ☐valve problems ☐NONE
**Genitourinary** ☐blood in urine ☐ hesitancy ☐incontinence ☐increased urgency ☐decreased frequency ☐excessive urination ☐kidney disease ☐kidney stones ☐NONE
**Gastrointestinal** ☐abdominal pain ☐ heartburn ☐blood in stool ☐vomiting ☐ulcers ☐constipation ☐diarrhea ☐trouble swallowing ☐decreased appetite ☐increased appetite ☐NONE
**Hematologic** ☐lower leg ulcers ☐sickle cell disease ☐anemia ☐blood thinners ☐clotting disorders ☐NONE
**Neurological** ☐tingling ☐ weakness ☐seizures ☐numbness ☐headaches ☐tremors ☐paralysis ☐NONE
**Musculoskeletal** ☐back pain ☐ joint swelling ☐muscle weakness ☐muscle pain ☐neck pain ☐sciatica ☐joint stiffness ☐joint pain ☐joint instability ☐arthritis ☐NONE
**Respiratory** ☐chest pain ☐ wheezing ☐COPD ☐coughing ☐snoring ☐shortness of breath ☐vascular disease ☐valve problems ☐NONE

## Privacy Information

Who can we discuss your care with? ☐wife ☐Husband ☐Daughter ☐Son ☐Parent ☐Other

Please list:_____

**PLEASE READ AND SIGN:**
Assignment of benefits: I authorize payment of medical benefits to the practice of Billie A. Bondar, DPM. Release of information: I authorize the release of any medical information necessary to process the claim. HIPPA: I understand I am entitled to a copy of the Privacy Practice Notice upon request. Medication history: I authorize the doctor and/or medical staff to retrieve my medication history.
The information on my intake forms is correct to the best of my knowledge. I understand that throughout my treatment I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature:_____ Date_____

Authorized agent Signature:_____Date:_____

Printed Name:_____