# Dr. Jessica Bordon

## Patient Information

Name:_____ Date of Birth _____

Address:_____ City:_____ State:_____ Zip_____

Primary Phone (_____)_____ Secondary Phone (_____) _____ Other Phone (____)_____ ☐ Male ☐ Female

SS# _____-____-_____ Email address _____

Race_____ Ethnicity _____ Preferred language _____

Marital Status ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Person to contact in case of emergency_____ Phone_____ Relationship_____

Preferred pharmacy _____ Location: _____

Primary Care physician _____ Last visit _____ Referred by ☐ same _____

## Insurance Information

Name of Insured (if other than self)_____ DOB_____

SSN#:_____ Relationship to Patient _____

**Financial Responsibility/Assignment of Benefits**

As a courtesy to you, our office will file insurance for all reimbursable services to both your primary and secondary insurance carriers. While we do our best to accurately predict your insurance coverage, sometimes our estimates are inaccurate due to circumstances beyond our control. Should your insurance not pay as we expect, or does not pay in a timely manner, you will be responsible for the unpaid portion of your charges.

I assign to Jessica D. Bordon, DPM, PA, any insurance or other third party benefits available for health care services provided to me. I understand that Jessica D. Bordon, DMP, PA has the right to refuse or accept assignment of such benefits.

I have been given the opportunity to read the clinic's patient policies and procedures. The policies are available upon request.

_____ _____

Signature of Patient or Responsible Party Date

## HIPAA Information

Protected health information (PHI) will only be released from our practice with a properly executed authorization from the patient or his/her personal representative, except for treatment, payment, or health care operations and as otherwise required by law. Examples of some instances in which we are required to disclose your PHI include: Public health activities; information regarding victims of abuse, neglect, or domestic violence; health oversight activities; judicial and administrative proceedings; law enforcement purposes; organ donations purposes; research purposes under certain circumstances; national security and intelligence; and correctional institutions. **Jessica D. Bordon, DPM, PA** will only use or disclose PHI, except as noted above, consistent with the terms of the authorization.

I understand that I have the right to review the notice of Privacy Practices that provides a more complete description of information uses and disclosures.

Dr. Bordon may share my PHI with the following additional person(s): _____

Signature_____ Date _____

## Past Medical History:

☐Allergies
☐Anemia
☐Arthritis
☐Asthma
☐Blood Clot
☐Blood Transfusion
☐Cancer
What kind?_____
☐Chicken Pox
☐Chronic Bronchitis
☐Colon Polyps
☐Crohn's Disease or IBS
☐Diabetes
☐Diverticulitis
☐Eczema
☐Frequent UTI's
☐Frequent Sinus Infections
☐Gallstones
☐Glaucoma
☐Gout
☐Heart Condition
Specify _____
☐Heart Attack
☐Hepatitis
☐Other liver problems
☐High Blood Pressure
☐High Cholesterol
☐Kidney Disease
☐Kidney Infections
☐Kidney Stones
☐Migraines
☐Osteopenia
☐Osteoporosis
☐Prostate Problems
☐Psoriasis
☐Reflux (heartburn)
☐Rheumatoid Arthritis
☐Rosacea
☐Seizures
☐STD
☐Stomach Ulcers
☐Stroke
☐Thyroid disease
☐Tuberculosis
☐Ulcerative Colitis
☐Warts
☐Other_____
☐ **None**

## Surgical History:

| Surgery | Year |
|---|---|
| ☐**None** | |
| ☐Appendectomy | _____ |
| ☐Back Surgery | _____ |
| ☐Cataract Surgery | _____ |
| ☐Cesarean Section | _____ |
| ☐Gallbladder Removal | _____ |
| ☐Heart Surgery | _____ |
| Specify _____ | |
| ☐Hemorrhoid Surgery | _____ |
| ☐Hernia | _____ |
| ☐Hysterectomy | _____ |
| ☐Joint Surgery | _____ |
| ☐ Lumpectomy | _____ |
| ☐Plastic Surgery | _____ |
| ☐Polyp Removal (Colon) | _____ |
| ☐Tonsillectomy/Adenoidectomy | _____ |
| ☐Tubal Ligation or Vasectomy | _____ |
| ☐Lower extremity bypass or stent | _____ |
| ☐Foot surgery | _____ |
| ☐Other | _____ |

## Family History:

| Grandparent | Sibling | Mother | Father | ☐None |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ Heart Disease/Attack |
| ☐ | ☐ | ☐ | ☐ | ☐ Stroke |
| ☐ | ☐ | ☐ | ☐ | ☐ Diabetes |
| ☐ | ☐ | ☐ | ☐ | ☐ High Blood Pressure |
| ☐ | ☐ | ☐ | ☐ | ☐ High Cholesterol |
| ☐ | ☐ | ☐ | ☐ | ☐ Hypothyroidism |
| ☐ | ☐ | ☐ | ☐ | ☐ Depression |
| ☐ | ☐ | ☐ | ☐ | ☐ Other Mental Illness |
| ☐ | ☐ | ☐ | ☐ | ☐ Alcoholism |
| ☐ | ☐ | ☐ | ☐ | ☐ Asthma |
| ☐ | ☐ | ☐ | ☐ | ☐ Osteoporosis |
| ☐ | ☐ | ☐ | ☐ | ☐ Migraines |
| ☐ | ☐ | ☐ | ☐ | ☐ Other Illness: _____ |
| ☐ | ☐ | ☐ | ☐ | ☐ Colon Cancer |
| ☐ | ☐ | ☐ | ☐ | ☐ Prostate Cancer |
| ☐ | ☐ | ☐ | ☐ | ☐ Lung Cancer |
| ☐ | ☐ | ☐ | ☐ | ☐ Breast Cancer |
| ☐ | ☐ | ☐ | ☐ | ☐ Uterine Cancer |
| ☐ | ☐ | ☐ | ☐ | ☐ Ovarian Cancer |
| ☐ | ☐ | ☐ | ☐ | ☐ Skin Cancer |
| ☐ | ☐ | ☐ | ☐ | ☐ Other Cancer: _____ |

## Social History:

Highest Level of Education: ☐Less than 8th grade ☐Less than High School ☐High School ☐College ☐Graduate school ☐Professional

What type of work do you do? _____

What hobbies or activities do you enjoy? _____

Do you exercise? ☐ Yes ☐ No If so, what type and how often? _____

Did you injure your foot? ☐ Yes ☐ No If so, when and how? _____

_____

What type of shoes do you wear most? _____

What is your pain level on a scale of 1-10? _____ Have you had previous treatment? ☐ Yes ☐ No

### Tobacco Use:

☐Never Smoked
☐Ex-Smoker
Quit Date_____
☐Current Smoker
☐Current Smoke Exposure
☐Smokeless tobacco use

### Caffeine/Alcohol Use:

**Alcohol**
☐None
☐2 or less/day
☐3 or more/day

**Caffeine**
☐None
☐3 or less/day
☐4 or more/day

☐History of problems with alcohol

### Street Drug Use:

☐Never used street drugs
☐Past use
☐Current use

### Current Medications: Include over the counter medications and food supplements. Continue on back of page if needed.

| Drug Name | Dose | How Often | ☐ None |
|---|---|---|---|
| _____ | _____ | _____ | |
| _____ | _____ | _____ | |
| _____ | _____ | _____ | |

### Medication Allergies: Include any medication to which you have had a reaction.

| Drug Name | Reaction | ☐ None |
|---|---|---|
| _____ | _____ | |
| _____ | _____ | |

Please answer all questions based on how you are feeling today or the past few days in order for your provider to understand a complete picture of your health.

Constitutional
❑Y ❑N Fever
❑Y ❑N Recent weight gain
❑Y ❑N Recent weight loss

Eyes
❑Y ❑N Blurred Vision
❑Y ❑N Eye drainage

Ears/Nose/Throat
❑Y ❑N Ear pain
❑Y ❑N Hearing problems
❑Y ❑N Nasal congestion
❑Y ❑N Runny nose
❑Y ❑N Sore throat

Cardiovascular
❑Y ❑N Chest Pain
❑Y ❑N Dizziness
❑Y ❑N Heart Racing
❑Y ❑N Feet swelling
❑Y ❑N Fast heart rate

Respiratory
❑Y ❑N Recent cough
❑Y ❑N Chronic cough
❑Y ❑N Shortness of breath
❑Y ❑N Wheezing

Gastrointestinal
❑Y ❑N Abdominal pain
❑Y ❑N Constipation
❑Y ❑N Diarrhea
❑Y ❑N Nausea
❑Y ❑N Vomiting

Genitourinary
❑Y ❑N Painful urination
❑Y ❑N Genital lesions
❑Y ❑N Blood in urine
❑Y ❑N Irregular menstrual cycle
❑Y ❑N Urinary incontinence
❑Y ❑N Vaginal discharge
❑Y ❑N Vaginal itching

Musculoskeletal
❑Y ❑N Painful joints
❑Y ❑N Foot pain

Integumentary
❑Y ❑N Atypical mole
❑Y ❑N Rashes
❑Y ❑N Breast mass
❑Y ❑N Breast tenderness
❑Y ❑N Nipple discharge
❑Y ❑N Self breast exams

Neurological
❑Y ❑N Dizziness
❑Y ❑N Fainting
❑Y ❑N Headaches
❑Y ❑N Memory loss
❑Y ❑N Seizures

Hematic/Lymphatic
❑Y ❑N Excess bleeding
❑Y ❑N History of blood transfusion

Endocrine
❑Y ❑N Hair loss
❑Y ❑N Heat/cold intolerance
❑Y ❑N Abnormally increased thirst

Allergic/Immunologic
❑Y ❑N Seasonal allergies
❑Y ❑N Positive for HIV risk factors

# Clinic Policies

## Cancellation/no show policy

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed care. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you due to a seemingly "full" appointment book. In addition, there is often work involved in the way of scheduling and preparing for our patients which, in the case of no call/no show, results in wasted time and work for our staff. If an appointment is not cancelled 24 hours in advance, you will be charged a Fifty dollar fee ($50.00); this will not be covered by your insurance company and you will be required to pay this fee prior to being seen again. If you do not show up for an appointment without any notice more than once, you will be dismissed from our clinic and required to seek other care.

## Late for Appointment

We understand that delays can happen, however, we must try to keep the other patients and Dr. Bordon on time. If a patient is 10 minutes past their scheduled time, we will have to reschedule the appointment. Also, if you know you will be running behind for your appointment, please call and let our staff know.

## Cancellation/no show policy for surgery

Due to the large block of time needed for surgery as well as the extensive amount of preparation required, last minute cancellations can cause problems and added expenses for the office. If surgery is not cancelled at least 5 days in advance, you will be charged a fifty dollar fee ($50); this will not be covered by your insurance company and you will be require to pay this fee prior to being seen again.

## Account Balances

We will required that patients with balances pay their account balances to zero (0) prior to receiving further services by our practice. Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns. Patients with balances over $100 must make payment arrangements prior to future appointments being made.

## Insurance Policy

Guaranteeing that your insurance is in network with this clinic is the responsibility of THE PATIENT. For us to do this on every patient would monopolize all of our office's time as each contract is individual and different.

In order to verify that you insurance is contracted with Dr. Jessica Bordon, YOU MUST USE HER TAX ID #453675234. Her name alone is not a guarantee as she may have been contracted in the past an no longer is, or vice versa. We cannot guarantee that insurance companies have updated information based on her name. Therefore, her tax ID is the most reliable assurance of receiving in-network benefits.

Please be aware that if we are not contracted with your insurance, you will receive a bill that you will be responsible for.

Patient signature _____

Date _____