



LEGAL NOTICE/DISCLAIMER

The information contained in this document does not establish a standard of care, nor does it constitute legal advice. The information is for general informational purposes only and is written from a risk management perspective to aid in reducing professional liability exposure. Please review this document for applicability to your specific practice. You are encouraged to consult with your personal attorney for legal advice, as specific legal requirements may vary from state to state.

PATIENT NAME: _____

DATE OF BIRTH: ____/____/____

Sherene James Bond DPM, MS
6124 Landover Rd.
Cheverly, MD 20785
Phone: 240-828-8200
Fax: 240-828-8201



PATIENT INFORMATION FORM
(PLEASE PRINT)

DATE: ____/____/____

PATIENT NAME: _____ DATE OF BIRTH: ____/____/____ AGE: ____ SEX: M F
LAST FIRST MI

HOME ADDRESS: _____ CITY/STATE: _____ ZIP: _____

MAY WE LEAVE A MESSAGE?

HOME PHONE #: (____) ____ - ____ YES NO

WORK PHONE #: (____) ____ - ____ YES NO

CELL PHONE #: (____) ____ - ____ YES NO

E-MAIL: _____ YES NO

PRIMARY LANGUAGE: _____

RACE: _____

ETHNICITY: _____

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO

IF YES, NAME: _____ RELATIONSHIP: _____ PHONE #: (____) ____ - ____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE #: (____) ____ - ____

PRIMARY CARE DOCTOR: _____ PHONE: _____

PHARMACY: _____ LOCATION: _____ PHONE #: (____) ____ - ____

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?

____ YES NAME(S) _____

____ NO

WHO IS RESPONSIBLE FOR PAYMENT? _____ RELATIONSHIP TO PATIENT? _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____ - ____

WHO REFERRED YOU TO US? _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____ - ____

INSURED NAME: _____ DATE OF BIRTH _____ EMPLOYER _____

CONTRACT # _____ GROUP # _____

PATIENT NAME: _____

DATE OF BIRTH: ____/____/____

SECONDARY INSURANCE COMPANY NAME:

ADDRESS: _____ **CITY/STATE:** _____ **ZIP:** _____

PHONE #: (____) ____-____

INSURED NAME: _____ **DATE OF BIRTH** _____ **EMPLOYER** _____

CONTRACT # _____ **GROUP #** _____

Sherene James Bond DPM, MS

6124 Landover Rd.

Cheverly, MD 20785

Phone: 240-828-8200

Fax: 240-828-8201

PATIENT NAME: _____

DATE OF BIRTH: ____/____/____

Sherene James Bond DPM, MS

6124 Landover Rd.

Cheverly, MD 20785

Phone: 240-828-8200

Fax: 240-828-8201

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE
PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME

DOSE

HOW OFTEN DO YOU TAKE?

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY

DATE

TYPE OF SURGERY

DATE

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION

DATE

REASON FOR HOSPITALIZATION

DATE

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE

☐ CURRENT USE - Type _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ ☐ SMOKE ____ PACKS/DAY FOR ____ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ TYPE _____

☐ CURRENT USE - Type _____ ☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

EMPLOYER: _____ OCCUPATION: _____

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? ☐ CHILDREN – AGE(S) _____ ☐ PET(S) – WHAT KIND? _____

☐ ELDERLY OR DISABLED FAMILY MEMBER ☐ OTHER _____

EXERCISE: ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY

TYPES OF EXERCISE: _____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES: TYPE 1 OR TYPE 2 ☐ CANCER ☐ HEART DISEASE

☐ HIGH BLOOD PRESSURE ☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE

PATIENT NAME: _____

DATE OF BIRTH: ____/____/____

Sherene James Bond DPM, MS

6124 Landover Rd.

Cheverly, MD 20785

Phone: 240-828-8200

Fax: 240-828-8201

☐ RHEUMATOID ARTHRITIS

☐ OTHER

YOUR MEDICAL HISTORY

ALLERGIES: ☐ MEDICATIONS _____

☐ ANESTHESIA _____ ☐ FOODS _____

☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER _____

☐ NONE KNOWN

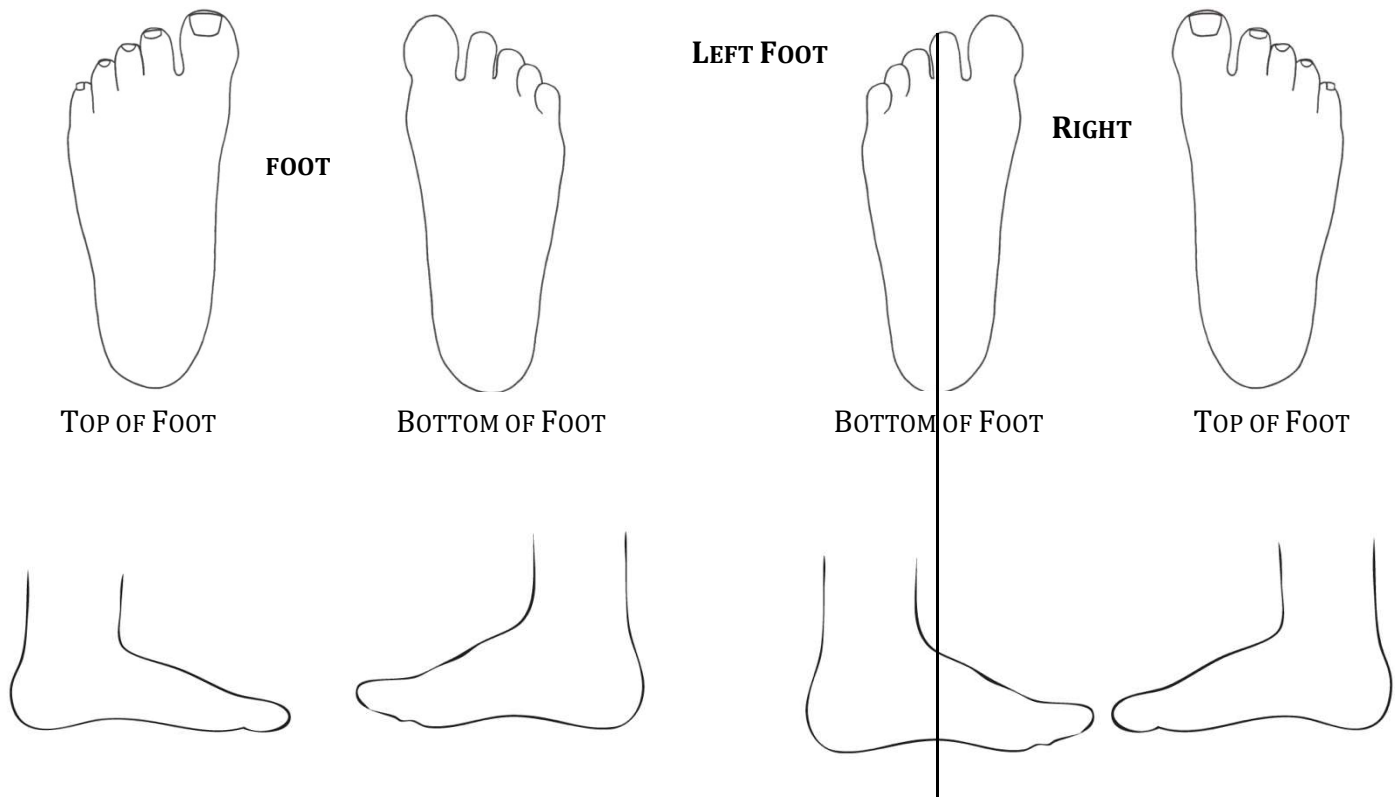
HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES: TYPE 1 OR TYPE 2 (CIRCLE)	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N
OTHER CONDITIONS:								

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.



PATIENT NAME: _____
DATE OF BIRTH: ____/____/____

Sherene James Bond DPM, MS
6124 Landover Rd.
Cheverly, MD 20785
Phone: 240-828-8200
Fax: 240-828-8201

INSIDE OF FOOT OUTSIDE OF FOOT OUTSIDE OF FOOT INSIDE OF FOOT

HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: ☐ BEGIN ALL OF A SUDDEN ☐ GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? ☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING
☐ RADIATING ☐ ITCHING ☐ STABBING ☐ OTHER _____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)

(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORST PAIN POSSIBLE)

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: ☐ STAYED THE SAME ☐ BECOME WORSE ☐ IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? ☐ WALKING ☐ STANDING ☐ DAILY ACTIVITIES
☐ RESTING ☐ DRESS SHOES ☐ HIGH HEELS ☐ FLAT SHOES ☐ ANY CLOSED TOE SHOE
☐ RUNNING ☐ OTHER _____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? _____

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? _____

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ YES (DESCRIBE) _____ ☐ NO

IF YES, WAS IT A WORK-RELATED INJURY? ☐ YES ☐ NO

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

PRINT NAME OF PATIENT, PARENT OR GUARDIAN

SIGNATURE OF DOCTOR

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

DATE

SIGNATURE

DATE

PATIENT NAME: _____

DATE OF BIRTH: ____/____/____

Sherene James Bond DPM, MS
6124 Landover Rd.
Cheverly, MD 20785
Phone: 240-828-8200
Fax: 240-828-8201



BRONZE
FOOT AND ANKLE CENTER

Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.
- There is a service fee of \$25.00 for all returned checks. and appointment that are not cancelled within a 24hr notice. Your insurance company does not cover this fee.

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party _____ Date: _____

_____ Patient initials to indicate copy received.