



**SURGERIES:**

LIST ALL SURGERY

DATE

TYPE OF SURGERY

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  CANCER  HEART DISEASE  HIGH BLOOD PRESSURE

STROKE  CORONARY ARTERY DISEASE  THYROID DISEASE  RHEUMATOID ARTHRITIS

AMPUTATION  OTHER \_\_\_\_\_

**YOUR MEDICAL HISTORY**

ALLERGIES:  MEDICATIONS \_\_\_\_\_

ANESTHESIA \_\_\_\_\_  FOODS \_\_\_\_\_

TAPE  LATEX  SHELLFISH  IODINE  OTHER \_\_\_\_\_  NONE KNOW

**HAVE YOU EVER HAD ANY OF THE FOLLOWING?**

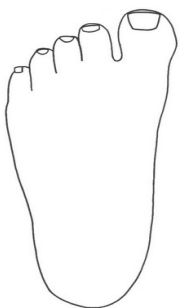
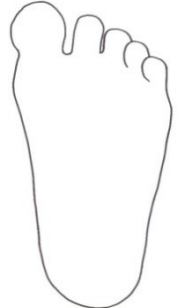

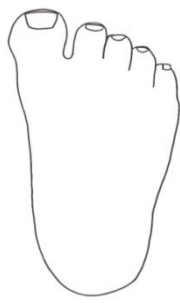
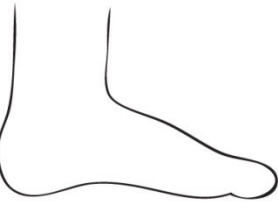

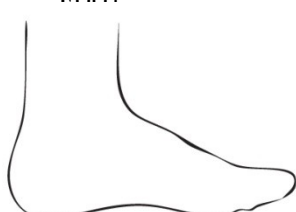
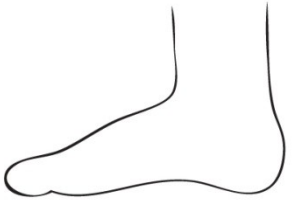
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES/WOUND	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	OSTEOPOROSIS/OSTEOPENIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
ABNORMAL BLEEDING	Y	N	HEPATITIS/LIVER DISEASE	Y	N	PNEUMONIA	Y	N
ADHD	Y	N	HIGH BLOOD PRESSURE	Y	N	PSORIASIS	Y	N
BLOOD CLOTS	Y	N	HIGH CHOLESTEROL	Y	N	PSYCHIATRIC CARE	Y	N
CANCER	Y	N	HIV POSITIVE/AIDS	Y	N	RAYNAUD'S DISEASE	Y	N
CHF	Y	N	KIDNEY DISEASE	Y	N	SEIZURES	Y	N
COPD/EMPHYSEMA	Y	N	LEG STENTS	Y	N	SICKLE CELL DISEASE/TRAIT	Y	N
DEPRESSION/ANXIETY	Y	N	LUPUS	Y	N	SKIN DISORDER/CANCER	Y	N
DIABETES/PRE DIABETES	Y	N	MELANOMA	Y	N	SLEEP APNEA	Y	N
DIABETIC RETINOPATHY	Y	N	MEMORY LOSS	Y	N	STOMACH ULCERS	Y	N
FIBROMYALGIA	Y	N	MITRAL VALVE PROLAPSE	Y	N	STROKE/MINI STROKE	Y	N
GERD	Y	N	NEUROPATHY	Y	N	THYROID DISEASE	Y	N
OTHER CONDITIONS:								

**CURRENT PROBLEM**

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY?

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

LEFT FOOT		RIGHT FOOT	
			
TOP OF FOOT	BOTTOM OF FOOT	BOTTOM OF FOOT	TOP OF FOOT
			
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:  BEGAN ALL OF A SUDDEN  GRADUALLY DEVELOPS 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

**OLGA GARCIA LUEPSCHEN, DPM PA**

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**

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT \_\_\_\_\_

DATE \_\_\_\_\_

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice of Privacy.

PRINT NAME OF PATIENT, PARENT OR GUARDIAN \_\_\_\_\_

DATE \_\_\_\_\_

SIGNATURE \_\_\_\_\_

**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, 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. If your insurer sends the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- 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 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.
- 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**. Your insurance company does not cover this fee.
- There is a service fee of **\$50.00** for any **missed appointments**. Your insurance company does not cover this fee.
- There is a service fee of **\$10.00** for a **second time billing statement mailed**. Your insurance company does not cover this fee.

Signature of Patient/Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Patient/Responsible Party \_\_\_\_\_ Date: \_\_\_\_\_

**ASSIGNMENT OF BENEFITS**

I have read the above policy regarding my financial responsibility to Olga Garcia Luepschen, DPM, PA for providing medical services to me or the below named patient. I agree to pay Olga Garcia Luepschen, DPM, PA any amount due after insurance payment has been made by my carrier and any contractual adjustments have been credited or full amount of all bills incurred by me or the below named is no health insurance coverage.

I, the undersigned certify that (or my dependant) have coverage with my insurance as presented and assign directly to Olga Garcia Luepschen, DPM,PA insurance benefits, payable to me for service rendered. I understand that I am responsible for payment of Deductibles, co-payment, and/or non-covered service and/or non-covered foot care products. I hereby authorize the doctor to release all necessary information to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance Carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions. I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information.

Patient Full Name (PRINT) \_\_\_\_\_ Patient Signature \_\_\_\_\_ Date \_\_\_\_\_