GENTLE FOOT CARE CENTER
PATIENT INFORMATION FORM

DATE: ___/____/____

(PLEASE PRINT)

PATIENT NAME: ________________________ ________________________ ______
LAST FIRST MI

HOME ADDRESS: ______________________________ CITY/STATE: ________________ ZIP: __________

MAY WE LEAVE A MESSAGE?

HOME PHONE #: (____) ____-_______ YES NO CELL PHONE #: (____) ____-_____ YES NO

WORK PHONE #: (____) ____-_______ YES NO E-MAIL: ______________________________

Height: ____________ Weight: ______________ BIRTH DATE: ___/___/___ AGE: ___ SEX: M F

Race:
- ☐ White
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander

Ethnicity
- ☐ Not Specified
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Social Security#______________________________

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

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

WHO REFERRED YOU TO US? ____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: ____________________________________

PHONE #: (____) ____-_____ CONTRACT # ____________ GROUP # ____________

SECONDARY INSURANCE COMPANY NAME: ____

PHONE #: (____) ____-_____ CONTRACT # ____________ GROUP # ______________

INSURED NAME: ___________ ___________ DATE OF BIRTH _________ EMPLOYER __________________

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

NAME DOSE HOW OFTEN DO YOU TAKE?

____

____

____

____

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? ____

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____________