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**I. Patient Information**

Name \_\_\_\_\_  
Address of Financially Responsible Party \_\_\_\_\_  
(No P.O. Boxes)  
Zip \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Home Phone #( ) \_\_\_\_\_ Phone# of Financially Responsible Party ( ) \_\_\_\_\_  
Mobile Phone #( ) \_\_\_\_\_ E-Mail address \_\_\_\_\_  
Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Marital Status M \_\_\_ S \_\_\_ D \_\_\_ W \_\_\_ Sex M \_\_\_ F \_\_\_  
Social Security # \_\_\_\_\_ Drivers License # \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone #( ) \_\_\_\_\_  
Occupation \_\_\_\_\_ Responsible for Payments \_\_\_\_\_  
In Case Of Emergency Contact: \_\_\_\_\_ Phone #( ) \_\_\_\_\_

**II. Referred By:** Dr. \_\_\_\_\_ Friend or Relative \_\_\_\_\_  
Yellow Pages: \_\_\_\_\_ Pacific Bell \_\_\_\_\_ Verizon \_\_\_\_\_ Insurance Handbook \_\_\_\_\_

**III. Primary Insurance:** PPO \_\_\_ HMO \_\_\_ Medicare \_\_\_ Cash \_\_\_ Other \_\_\_

Insurance Company Name \_\_\_\_\_  
Deductible \_\_\_\_\_ Co-Pay \_\_\_\_\_ Referral Required \_\_\_ Yes \_\_\_ No  
Subscriber's Name \_\_\_\_\_ Subscriber's Phone #( ) \_\_\_\_\_  
Subscriber's Birthdate \_\_\_\_\_ Sex \_\_\_ M \_\_\_ F  
Subscriber's Social Security # \_\_\_\_\_  
Patient Relationship to Subscriber Self \_\_\_ Spouse \_\_\_ Child \_\_\_ Other \_\_\_

**IV. Secondary Insurance:** PPO \_\_\_ HMO \_\_\_ Medicare \_\_\_ Cash \_\_\_ Other \_\_\_

Insurance Company Name \_\_\_\_\_

**V. Financial Policy**

We will submit your health claim to the provided health insurance carrier on your behalf. This does not guarantee payment by your insurance company. I understand that I am ultimately responsible for all services. Balances greater than 30 days from date of service will be charged 1.5 % per month (18 % per year). Payment is due at the time services are rendered.

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
(Parent or guardian signature required if patient is a minor)

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Reason for today's visit: (chief complaint) \_\_\_\_\_

Weight: \_\_\_\_\_ Shoe Size: \_\_\_\_\_

Current medications: \_\_\_\_\_

Allergies to medications: \_\_\_\_\_

Surgeries you have had: \_\_\_\_\_

**Current or past problems with: (Review of systems)**

	Yes	No	(if yes, explain)
Diabetes	___	___	_____
Eyes	___	___	_____
Ears/Nose/Throat/Mouth	___	___	_____
High blood pressure	___	___	_____
Heart (murmur, artificial valves)	___	___	_____
Lungs	___	___	_____
Stomach/bowel	___	___	_____
Kidneys	___	___	_____
Arthritis/muscles/joints	___	___	_____
Skin	___	___	_____
Psychological disorder	___	___	_____
Blood/bleeding disorder	___	___	_____
Allergic/immunologic	___	___	_____
Cancer	___	___	_____
Circulatory problems	___	___	_____
Liver disease	___	___	_____
Phlebitis	___	___	_____
Varicose veins	___	___	_____
Stroke	___	___	_____

**Females:** are you pregnant \_\_\_yes \_\_\_no      planning to become pregnant \_\_\_yes \_\_\_no

**Family History: (Past family & social history)**

No. of children: \_\_\_\_\_ age(s) \_\_\_\_\_

**Check the following medical conditions that have occurred in your family:**

<u>Disease</u>	<u>Mother</u>	<u>Father</u>	<u>Blood Relative</u>
Arthritis	___	___	___
Cancer	___	___	___
Diabetes	___	___	___
Eczema	___	___	___
Heart disease	___	___	___
High blood pressure	___	___	___
Lung disease	___	___	___
Malignant Melanoma	___	___	___
Skin cancer	___	___	___

**Social History:**

Who is your primary care or family doctor? \_\_\_\_\_

Do you live alone? \_\_\_no \_\_\_yes      Do you smoke? \_\_\_no \_\_\_yes -frequency \_\_\_\_\_

Do you drink alcohol? \_\_\_no \_\_\_yes-frequency \_\_\_\_\_      Do you use recreational drugs? \_\_\_no \_\_\_yes-frequency \_\_\_\_\_

Occupation \_\_\_\_\_ Hobbies/leisure activities \_\_\_\_\_

Reviewed: \_\_\_\_\_ Date \_\_\_\_\_ Update \_\_\_\_\_