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**I. Patient Information**

Name \_\_\_\_\_

Address of Financially Responsible Party (No P.O. Boxes) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone # \_\_\_\_\_ Mobile Phone # \_\_\_\_\_

E-Mail address \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Marital Status M \_\_\_ S \_\_\_ D \_\_\_ W \_\_\_ Sex M \_\_\_ F \_\_\_

Ethnicity: White \_\_\_ Latino \_\_\_ Asian \_\_\_ Black/AA \_\_\_ Other \_\_\_\_\_

If you prefer a language other than English, please list: \_\_\_\_\_

Social Security # \_\_\_\_\_ Drivers License # \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone # \_\_\_\_\_

Occupation \_\_\_\_\_ Responsible for Payments \_\_\_\_\_

In Case Of Emergency Contact: \_\_\_\_\_ Phone # \_\_\_\_\_

Pharmacy Name \_\_\_\_\_ Pharmacy # \_\_\_\_\_

**II. Referred By:** Dr. \_\_\_\_\_ Friend or Relative \_\_\_\_\_

Google \_\_\_\_\_ Yahoo \_\_\_\_\_ Other \_\_\_\_\_ Insurance Handbook \_\_\_\_\_

**III. Primary Insurance:**

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

Deductible Amount \_\_\_\_\_ Co-Pay Amount \_\_\_\_\_

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. 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)