The Santa Monica Podiatry Group, Inc.
1260 15th Street, #1014
Santa Monica, CA 90404
310.451.1618

PROVIDER OF SERVICE

- ❑ Terry J. Boykoff, D.P.M.
- ❑ David J. Aungst, D.P.M.
- ❑ Albemar Espiritu, D.P.M.
- ❑ Abbasseh Towfigh, D.P.M.
- ❑ Mark Wallen, D.P.M.

PERSONAL

Name _____ D.O.B. _____/_____/_____ M F
(Last) (First) (Middle)

Address _____
(Street - NO P.O. Boxes please) (City) (State) (zip)

Home Tel (_____)_____-_____ Mobile (_____)_____-_____

E-Mail _____ Social Sec. # _____

Pharmacy of Choice _____ Tel (_____) _____-_____
(Name) (City)

Emergency Contact _____ Tel (_____) _____-_____
(Last) (First)

Spouse _____
(Last) (optional) (First)

Race _____ Ethnicity _____ Marital Status _____ Primary Language _____
(optional) (optional) (optional) (optional)

REASON(S) FOR VISIT

1. _____

2. _____

YOUR PREFERRED MODE OF COMMUNICATION

The Santa Monica Podiatry Group has implemented a new system whereby you can receive reminders of your appointments. **What is your preferred mode of communications:** ❑ E-Mail ❑ Mobile text

EMPLOYMENT

Name of Employer (if minor, parent) _____ Tel (_____)_____-_____

Address _____
(Street) (City) (State) (zip)

Your Title _____

Spouse's Employer _____ Tel (_____)_____-_____ Title _____

INSURANCE

Insurance Provider _____ ❑ PPO ❑ HMO ❑ Cash ❑ Medicare ❑ Other

ACKNOWLEDGEMENT

Assignment and release: I hereby authorize my insurance to be paid directly to the undersigned physician. I am financially responsible for non-covered services. I also authorize the physician to release my information required.

Signature _____ Date_____

BRIEF MEDICAL HISTORY

When was your last check-up? _____

Are you in good health? ❑ Y ❑ N If no, explain: _____

Have you ever been hospitalized/had surgery? ❑ Y ❑ N If yes, explain: _____

Do you have a history of ❑ Diabetes ❑ Hypertension ❑ Heart Disease ❑ Poor Healing ❑ Anemia ❑ Cancer

Does any relative have a history of ❑ Diabetes ❑ Hypertension ❑ Heart Disease ❑ Poor Healing ❑ Anemia

Height _____(inches) **Weight** _____ (lbs.)

Tobacco Status: ❑ Current everyday smoker ❑ Current "some days" smoker
❑ Smoker ❑ Former smoker ❑ Never smoker

ALLERGIES

NAME	REACTION	SEVERITY

❑ No known drug allergies

MEDICATION (if you have a list please provide a copy for your files)

NAME	DOSAGE

SUPPLEMENTS/VITAMINS

NAME	DOSAGE

REFERRING INFORMATION

Referred by _____

Primary Care Doctor _____ **Tel** (_____) _____-_____

Office Administrative Fees: X-Ray copies $15/CD, Chart copy $25+, Disability forms $50 each, New health/life insurance policy forms $50 each, Jury summons, travel cancellation, health club forms $25 each. Appointment "No-Show" (failure to give 24-hr cancellation notice) $60, NSF check charges $25.