Los Gatos foot & Ankle Center
Dr.Joan Oloff, D.P.M., F.A.C.F.A.S.,M.S.
Dr.Kelly Nix, F.A.C.F.A.S.

Patient Information

Referred By: _____

Last Name: _____ ☐ Mr. ☐Mrs. ☐ Miss ☐ Other _____ Sex: Male _____ Female _____

First Name: _____ Date of Birth: ___/___/_____ Age _____ SSN: _____-____-_____

Middle Name: _____ Preferred Name: _____ Primary Language: _____

Marital Status: ☐Married ☐Single ☐Separated ☐Divorced ☐Widowed Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino

Race: ☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐Native Hawaiian or OPI ☐White

Student Status: ☐Full ☐Part ☐N/A School:_____ Employment: ☐Full ☐Part ☐N/A Employer: _____

ADDRESS: _____City: _____County_____ State: _____ Zip: _____

Email Address: _____

Phone: Home ( ) _____ Work ( ) _____ Cell: ( ) _____

May we leave a voice message to remind you about appointments at your home or cell phone number? Yes _____ No _____

May we leave a voice message for normal test results at your home or cell phone number? Yes _____ No _____

(Complete only if you want the Practice to contact you at an address/phone different than you gave above)

Other Address: _____City: _____ State:_____ Zip: _____ Other Phone ( ) _____

_____

Pharmacy Name and Phone Number: _____

Emergency Contact Name _____

Relationship_____ Home Phone ( )_____ Work Phone ( )_____

GUARANTOR / Responsible Person (if different from patient)

Last Name: _____ ☐ Mr. ☐Mrs. ☐ Miss ☐ Other _____ Sex: Male _____ Female _____

First Name: _____ Date of Birth: ___/___/___ Age _____ SSN: _____-____-_____

Middle: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home ( ) _____ Work ( ) _____ Cell: ( ) _____

Guarantor Email Address: _____

Primary Insurance

Insurance Company: _____

Policyholder Name: _____

Member or Policyholder ID#: _____

Policy Holder Date of Birth:_____

Insurance Co. Phone Number: (____)_____

Group #_____

Insurance Co. Address: _____

City:_____ State:_____ Zip:_____

Secondary Insurance

Insurance Company: _____

Policyholder Name: _____

Member or Policyholder ID#: _____

Policy Holder Date of Birth: _____

Insurance Co. Phone Number:(____)_____

Group #_____

Insurance Co. Address: _____

City:_____ State:_____ Zip:_____