Los Gatos Foot & Ankle Center
Dr. Joan Oloff, D.P.M., F.A.C.F.A.S. ,M.S.
EMAIL: staff@losgatosfootandankle.com

Primary Care Physician: _____
Referred By: _____
Today's Date:_____

Identifying Information

Last Name: _____ □Mr. □Mrs. □Miss □Other _____ **Sex:** Male _____Female _____

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

Middle Name: _____ **Preferred Name:** _____

Marital Status: □Married □Single □Separated □Divorced □Widowed

Ethnicity: □Decline to Specify **Race(s):** _____ **Preferred Language:** _____

Employment Status: □Full □Part □Student **Employer Name:** _____

Email Address: _____

Home Address: _____

City: _____ **County:** _____ **State:** _____ **Zip:** _____

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

Preferred Method of Contact (Please Check One): □E-mail □Mail □Home □Cell □Work

PERFERRED APPOINTMENT REMINDER METHOD □ TEXT □ EMAIL

Pharmacy Information

Pharmacy Name: _____ **Pharmacy Number:** ( ) _____

Pharmacy Cross Streets: _____

Emergency Contact/Guardian

First Name: _____ **Last Name:** _____

Relationship to Patient: _____

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

Primary Insurance

Insurance Company: _____
Policyholder Name: _____
Member ID number: _____
Policy Holder Date of Birth: _____
Insurance Co. Phone Number: _____
Group #: _____
Insurance Address: _____
City: _____ State: _____ Zip: _____

Secondary Insurance

Insurance Company: _____
Policyholder Name: _____
Member ID number: _____
Policy Holder Date of Birth: _____
Insurance Co. Phone Number: _____
Group #: _____
Insurance Address: _____
City: _____ State: _____ Zip: _____