

WELCOME TO OUR OFFICE

Katheryne W. Glantz, D.P.M.
2345 E. Prater Way, Suite 315
Sparks, NV 89434

Vista Medical Terrace
(775) 331-3668

Today's Date _____

We are very glad to have you as a patient. Please answer the following questions to help us become better acquainted. If you need any help, please do not hesitate to ask for assistance.

Patient's Full Name _____ SS# _____
Last First MI

By what name do you wish to be addressed? _____ Date of Birth _____ Sex: M ___ F ___

Resident Address: _____ City _____ State ___ Zip _____

Home Phone# _____ Cell# _____ Other Phone# _____

Mailing Address: _____ City _____ State ___ Zip _____

Employer: _____ Occupation: _____

Work Address: _____ City _____ State ___ Zip _____

Is there any immediate family member who is a patient? _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

Your Family Physician: _____ Marital Status:

Name of Spouse or Parents: _____ ___ Single

In Case of an Emergency Contact: _____ Phone# _____ ___ Married

Person Responsible for Payment: _____ Relationship: _____ ___ Divorced

Address (if other than above): _____ Phone# _____ ___ Widowed

INSURANCE INFORMATION

Is the patient covered by medical insurance? Yes or No /By Medicare? Yes or No/ Worker's Comp.? Yes or No

Primary Insurance _____ **Secondary** _____

Policyholder's Name _____ Policyholder's Name _____

Date of Birth _____ Date of Birth _____

Policyholder's Employer _____ Policyholder's Employer _____

Policyholder's SS# _____ Policyholder's SS# _____