ARCH CITY
FOOT AND ANKLE

Dennis M. Timko, D.P.M.
SURGEON PODIATRIST/FOOT SPECIALIST

Eureka
521 North Virginia Ave.
Eureka, MO 63025
Tel: (800) 707-0215

Downtown
916 Olive Ste 3N-2
St. Louis, MO 63101
Tel: (800) 707-0215

PATIENT INFORMATION:

Last Name: First: Middle Initial:

Date of Birth: Age: Social Security #:

Sex: Marital Status: E-Mail Address:

Street Address: Apt #:

City: State: Zip: Home Phone:

Work Phone: Cell Phone:

WHOM MAY WE THANK FOR REFERRING YOU?

Newspaper / Yellow Pages / Website / Family / Friend / Physician / Other:

Name:

Address: City: State: Zip:

PRIMARY CARE PHYSICIAN:

Dr. ***Exact Date of Last Visit:**

Address/Location: Phone:

Are you under regular care for a specific problem?

EMERGENCY CONTACT:

Name: Relationship: Phone:

PATIENT EMPLOYER INFORMATION:

Occupation:

Employer: Phone:

Address: City: State: Zip:

INSURANCE INFORMATION:

Who is financially responsible for this account?

Primary Insurance: Insured Name:

Date of Birth: Relationship to Patient:

Primary Insurance ID # Primary Insurance Group #

Secondary Insurance: Insured Name:

Date of Birth: Relationship to Patient::

Secondary Insurance ID # Secondary Insurance Group #

PLEASE PRESENT YOUR INSURANCE CARD AND PHOTO ID. (A copy will become part of your medical record)

What is your current foot/ankle problem? (Be Specific):
Right / Left /Both
When did it begin?
How have you treated this problem so far?
Have you seen another doctor for this problem? If so, whom?
Have you ever seen a foot doctor? If so, when?

MEDICAL HISTORY: (Please check all that apply)

Major Disease:
- ❑ Diabetes
- ❑ High Blood Pressure
- ❑ Bleeding Disorders
- ❑ Heart Attack
- ❑ Stroke
- ❑ Cancer
- ❑ Hepatitis
- ❑ Thyroid Problems
- ❑ Liver Disease
- ❑ Gout
- ❑ Tuberculosis

HEENT:
- ❑ Headaches
- ❑ Blurred Vision
- ❑ Double Vision
- ❑ Hearing Loss

Respiratory:
- ❑ Asthma
- ❑ Lung Disease
- ❑ Shortness of Breath

Psychological:
- ❑ Anxiety
- ❑ Depression

Vascular:
- ❑ Swollen Feet/Legs
- ❑ Varicose Veins
- ❑ Poor Circulation
- ❑ Night Cramps
- ❑ Leg Ulcers
- ❑ Blood Clots
- ❑ Discoloration Legs/Feet

Arthritis:
- ❑ Back Pain
- ❑ Joint Pain
- ❑ Pain in Hands
- ❑ Pain in Feet

Gastrointestinal:
- ❑ Nausea
- ❑ Vomiting
- ❑ Ulcers

Podiatric Conditions:
- ❑ Corns/Calluses
- ❑ Numbness in Feet
- ❑ Bunions
- ❑ Heel Pain

Other:
- ❑_____
- ❑_____
- ❑_____

❑ Latex Allergy **ALLERGIES: (List any medication allergies)**_____

Height: _____ Weight:_____ Shoe Size:_____ (We use this information for orthotics/shoes)

ADVANCED DIRECTIVE:

Do you have a living will or advanced directive?

❑ Yes ❑ No

SOCIAL HISTORY: (Please check all that apply)

Tobacco use? Yes or No, Packs per day?_____

How many years?_____

Alcohol Use? Yes or No, Usage:_____

Pregnant? Yes or No, Pregnant Due Date:_____

ASSIGNMENT/RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage stated above and assign to Arch City Foot & Ankle all insurance benefits, if any, otherwise payable to me for services rendered.

I understand that I am financially responsible for all charges whether or not paid by insurance, and I, may be billed for additional costs incurred in the collection of these accounts. I understand that it is my responsibility to know and understand my insurance plan.

I hereby authorize Arch City Foot & Ankle's office to release any private health information necessary in treatment, payment or health care operations. I authorize the use of this signature on all insurance claim submissions. I understand. I may revoke this release only in writing. I understand that this office does leave voicemail messages if they are unable to contact patients, unless instructed in writing not to do so.

I certify that the information I have provided Arch City Foot & Ankle's office is true and correct to the best of my knowledge.

I give permission to Dr. Timko and staff to administer and perform such procedures as may be deemed necessary in my diagnosis and/or treatment on this visit as well as subsequent visits.

Signature of Responsible Party:_____Date: _____