Dennis M. Timko, D.P.M.
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Eureka, MO
1 Hilltop Village Center Dr.Eureka, MO, 63025
636-486-0033

PATIENT INFORMATION:

Last Name:_____First:_____Middle Initial:____
Date of Birth:_____ Age:_____ Social Security #:_____-_____-_____
Sex: M F Marital Status: Married, Single, Divorced, Widowed E-Mail Address:_____
Street Address:_____
City:_____ State:_____ Zip:_____ Home Phone:_____
Work Phone:_____ Cell Phone:_____

WHOM MAY WE THANK FOR REFERRING YOU?

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

PRIMARY CARE PHYSICIAN:

Dr._____

***Exact Date of Last Visit:_____**

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 #_____

What is your current foot/ankle problem? (Be Specific):

_____

_____

Which foot/ankle/leg? 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 (Circle all the apply)

Major Disease: Diabetes/ High Blood Pressure/ Heart Attack/ Stroke Cancer/ Depression

HEENT: Headaches/ Nausea/ Vomiting/ Hearing Loss/ Blurred Vision/ Double Vision/ Thyroid Problems

Vascular: Swollen Feet/Legs/ Varicose Veins/ Bleeding Disorders/ Poor Circulation/ Night Cramps/ Discoloration Legs/Feet/ Blood Clots

Gastrointestinal: Ulcers/ Hepatitis/ Liver Disease

Podiatric (Foot) Conditions: Leg Ulcers/ Corns/Calluses/ Bunions/ Numbness in Feet/ Heel Pain/ Pain in Feet

Respiratory: Asthma/ Lung Disease/ Shortness of Breath/ Tuberculosis

Arthritis: Gout/ Joint Pain/ Pain in Hands/ Back Pain

Psychological: Anxiety/ Depression

Other: _____

Past Surgery (Dates and detail)

_____

_____

_____

LIST OF MEDICATIONS (including Over the counter and Vitamins):

_____

_____

_____

Pharmacy name: _____

Pharmacy phone number: _____

Latex Allergy: Y or N

OTHER ALLERGIES: (List any medication allergies and reaction)_____

_____

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

SOCIAL HISTORY: (Please check all that apply)

Tobacco use? Yes or No, Packs per day?_____ How many years tobacco use?_____ How many year(s) quite?_____

Alcohol Use? Yes or No, Usage (avg per week) :_____ Pregnant? Yes or No, Pregnant Due Date:_____

ADVANCED DIRECTIVE:

Do you have a living will or advanced directive?

Yes No

CONSENT TO TREAT AND BILL INSURANCE:

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:_____

Print name of Responsible Party:_____

Privacy of Practice Signature Acknowledgement

I have received a copy of the Privacy of Practices of Arch City Foot & Ankle PC.

Signature of Responsible Party:

_____Date:_____

Relationship to patient:

_____

Print name of Responsible Party:

_____