



PATIENT INFORMATION

Today's date: _____

Last Name: _____ First Name: _____ Middle Initial: _____
Date of Birth: _____ Social Security Number: _____ - _____ - _____
Sex: M F Marital Status: Married Single Divorced Widowed
Street Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Email address (for Onpatient portal access): _____

WHOM MAY WE THANK FOR REFERRING YOU?

Insurance Website Family Friend Physician Other:

PRIMARY CARE PHYSICIAN

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

Are you under regular care for a specific problem? Y N If so, what?

If diabetic, name of treating physician: _____ **Date of Last Visit:** _____

PHARMACY

Name: _____ Phone: _____ Location: _____

EMERGENCY CONTACT

Name: _____ Phone: _____ Relationship: _____

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 # _____

MEDICAL HISTORY (check all that apply)

Major Disease <input type="checkbox"/> Type 1 Diabetes <input type="checkbox"/> Type 2 Diabetes <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Attack <input type="checkbox"/> Stroke <input type="checkbox"/> Cancer <input type="checkbox"/> Thyroid	HEENT <input type="checkbox"/> Headache <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Double Vision <input type="checkbox"/> Hearing Loss Respiratory <input type="checkbox"/> Asthma <input type="checkbox"/> Lung disease <input type="checkbox"/> Shortness of breath	Vascular <input type="checkbox"/> Swollen legs/feet <input type="checkbox"/> Varicose veins <input type="checkbox"/> Bleeding disorders <input type="checkbox"/> Poor circulation <input type="checkbox"/> Night cramps <input type="checkbox"/> Blood clots <input type="checkbox"/> Discoloration legs/feet <input type="checkbox"/> High cholesterol	Podiatric (Foot) <input type="checkbox"/> Foot/leg ulcers <input type="checkbox"/> Corns/calluses <input type="checkbox"/> Bunions <input type="checkbox"/> Numbness <input type="checkbox"/> Heel pain <input type="checkbox"/> Pain in feet <input type="checkbox"/> Gout
Gastrointestinal <input type="checkbox"/> Ulcers <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Kidney disease <input type="checkbox"/> Liver disease <input type="checkbox"/> Hepatitis	Psychological <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety	Arthritis <input type="checkbox"/> Joint pain <input type="checkbox"/> Pain in hands <input type="checkbox"/> Back pain	Other: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

SURGERIES (dates and details)

LIST OF MEDICATIONS (including over the counter and vitamins)

MEDICATION ALLERGIES? Y N

If yes, please list the specific medication and reaction: _____

LATEX ALLERGY? Y N

SOCIAL HISTORY

Tobacco use? Y N Packs per day: _____ How many years of tobacco use? _____

Alcohol use? Y N Average number of glasses per week: _____

Pregnant? Y N Due Date: _____

Height: _____ **Weight:** _____ **Shoe Size:** (for shoes/orthotics) _____

ADVANCED DIRECTIVE Do you have a living will or advanced directive? Y N

What is your current foot/ankle/leg 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? Y N If so, whom? _____

Have you ever seen a foot doctor? Y N If so, when? _____

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:

Relationship to patient:

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: _____

Print name of Responsible Party:

Relationship to patient:
