



Dennis M. Timko, D.P.M.
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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: _____
City: _____ State: _____ Zip: _____ Home _____
Phone: _____
Work Phone: _____ Cell Phone: _____

EMERGENCY CONTACT:

Name: _____ Relationship: _____ Phone: _____

PATIENT EMPLOYER INFORMATION:

Occupation: _____
Employer: _____
Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

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? _____

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) ONLY fill out if anything changed

Pharmacy phone number: _____

Latex Allergy: Y or N

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

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 consent to receive text messages to my above phone number, from Arch City Foot & Ankle for non-emergency patient care communications (appointment reminders, scheduling, follow-ups, billing, test results, etc.). I understand that standard text/email rates may apply depending on my phone plan, and that I can revoke this consent at any time by notifying the office in writing or by phone.

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: _____