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

**PATIENT INFORMATION:**

**Last Name:_____First:_____Middle Initial**:____

**Date of Birth**:_____Age:_____

**Social Security #**:_____-_____-_____**E-Mail:_____**

**Address:_____**

**City:_____ State:_____Zip:_____**

**Phone:_____**

**PRIMARY CARE PHYSICIAN:**

Dr._____PHONE:_____

**Month/Year of Last Visit:_____**

**EMERGENCY CONTACT:**

Name: _____Relationship: _____Phone: _____

**Pharmacy_____Location:_____**

**Height: _____ Weight:_____ Shoe Size:_____**

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:_____