ARCH CITY FOOT ANKLE

PATIENT INFORMATION **Todays 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	**Secondary Insurance**
Insured Name: _____	Insured Name: _____
Date of Birth: _____	Date of Birth: _____
Relationship to Patient: _____	Relationship to Patient: _____
Primary Insurance ID # _____	Secondary Insurance ID # _____
Primary Insurance Group # _____	Secondary Insurance Group # _____

MEDICAL HISTORY (check all that apply)

Major Disease
- ❑ Type 1 Diabetes
- ❑ Type 2 Diabetes
- ❑ High Blood Pressure
- ❑ Heart Attack
- ❑ Stroke
- ❑ Cancer
- ❑ Thyroid

Gastrointestinal
- ❑ Ulcers
- ❑ Nausea/Vomiting
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Hepatitis

HEENT
- ❑ Headache
- ❑ Blurred Vision
- ❑ Double Vision
- ❑ Hearing Loss

Respiratory
- ❑ Asthma
- ❑ Lung disease
- ❑ Shortness of breath

Psychological
- ❑ Depression
- ❑ Anxiety

Vascular
- ❑ Swollen legs/feet
- ❑ Varicose veins
- ❑ Bleeding disorders
- ❑ Poor circulation
- ❑ Night cramps
- ❑ Blood clots
- ❑ Discoloration legs/feet
- ❑ High cholesterol

Arthritis
- ❑ Joint pain
- ❑ Pain in hands
- ❑ Back pain

Podiatric (Foot)
- ❑ Foot/leg ulcers
- ❑ Corns/calluses
- ❑ Bunions
- ❑ Numbness
- ❑ Heel pain
- ❑ Pain in feet
- ❑ Gout

Other:
- ❑
- ❑
- ❑
- ❑

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 s 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:

_____