

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: _____