If information has changed since your last visit, fill in name, changes, and sign at the bottom.

If nothing has changed since your last visit, write SAME across document and sign at the bottom.

Boulder County Foot & Ankle, PC
Pearl Podiatry Health Center, LLC

John S. Jachimiak, DPM
James D. Yakel, DPM
2575 Pearl Street, Suite 240
Boulder, CO 80302
Office: (303) 442-2910
Fax: (303) 442-2931

Last Name:_____ First (Legal):_____ Middle Initial_____

Mailing Address:_____
(City) (State) (Zip)

Home Phone: ( )_____ Social Security #:_____ Cell/Pager #: ( )_____

Preferred Name:_____ Birth date: _____ Sex: M F Marital Status: M S W O

Height_____ Weight_____ Shoe Size_____ Email_____

Race: Asian African American Caucasian Hispanic Other Decline Preferred Language _____

Employer:_____ Occupation:_____ Work Phone: ( )_____ext_____

Spouse:_____ Primary Care Physician:_____ Phone #: ( )_____

May we contact you at your home #? Y N If no, please indicate which # you would like us to contact you ( )_____

Emergency Contact:_____ Relationship:_____ Phone #: ( )_____

Preferred Pharmacy_____ Phone # _____

Primary Insurance Information:

Insurance:_____ Policy Holder:_____ Relationship:_____ DOB_____

Policy Holder's Address:_____
(if different than above) (City) (State) (Zip)

Home Phone: ( )_____ Work Phone: ( )_____ Cell/Pager #: ( )_____

Employer:_____ Subscriber#:_____ Group# :_____

Secondary Insurance Information:

Insurance:_____ Policy Holder:_____ Relationship:_____ DOB_____

Policy Holder's Address:_____
(if different than above) (City) (State) (Zip)

Home Phone: ( )_____ Work Phone: ( )_____ Cell/Pager #: ( )_____

Employer:_____ Subscriber#:_____ Group#: _____

Person Responsible for Bill:

Name:_____ Relationship:_____

Mailing Address:_____
(if different than above) (City) (State) (Zip)

Home Phone: ( )_____ Work Phone: ( )_____ Cell/Pager #: ( )_____

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I hereby acknowledge and agree that if my account becomes delinquent it will be subject to collection service. I agree to pay all court costs and reasonable attorney fees for collection of all past due amounts owed, plus interest thereon on all such amounts outstanding. I certify that the information provided is correct to the best of my knowledge. I authorize the release of any pertinent information regarding my medical care, and assignment of benefits from my insurance company to my Physician.

Signature:_____ Date:_____

Parent or Guardian (if minor):_____ Date:_____

Must be filled out yearly

Boulder County Foot & Ankle, PC
Pearl Podiatry Health Center, LLC
John S. Jachimiak, DPM
James D. Yakel, DPM
2575 Pearl Street, Suite 240
Boulder, CO 80302
Office: (303) 442-2910
Fax: (303) 442-2931

MEDICAL HISTORY – Patient Name: _____

(Confidential Information-Important for Our Files and Your Health)

Please list all medicines that you use:

Medication	Strength	Dosage	Frequency	Comments

If you have complete list from your primary care doctor, please include with your paperwork and note in comment section above.

Please list all medicines that you are ALLERGIC to: _____
_____
_____
_____
_____
_____

Please list ANY Metal ALLERGIES: _____
_____
_____

Allergic to Latex: YES NO

_____ _____
Sign Name Date

_____
Print Name

Must be filled out yearly

Boulder County Foot & Ankle, PC
Pearl Podiatry Health Center, LLC
John S. Jachimiak, DPM
James D. Yakel, DPM
2575 Pearl Street, Suite 240
Boulder, CO 80302
Office: (303) 442-2910
Fax: (303) 442-2931

MEDICAL HISTORY – Patient Name: _____

(Confidential Information-Important for Our Files and Your Health)

Were you referred to our office by another Doctor? YES NO

If yes, who referred you? _____

Was this another Podiatrist? YES NO

If yes, Why did you see your former Podiatrist? _____
_____

What is the reason for your visit to our office? _____
_____
_____

What treatments have been done up to this point (including orthotics/arch supports)?
_____
_____

Do you, or have you ever, smoked? YES NO Date Quit_____

How many packs a day do you, or did you, smoke? _____

FOR WOMEN ONLY: Are you pregnant? YES NO If yes, how many months _____

Indicate which of your immediate relatives have had any of the following diseases:

Cancer_____ **Diabetes _____**
Heart Trouble _____ **High Blood Pressure _____**
Kidney Disease _____ **Mental/Emotional Illness _____**
Stroke _____ **Arthritis _____**