

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

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

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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**

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How did you hear about our practice?

- Facebook
- Our website / Google search
- Your insurance company's website _____

- Friend _____

- Referred by Doctor _____

- Referred by another 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 _____
Heart Trouble _____
Kidney Disease _____
Stroke _____

Diabetes _____
High Blood Pressure _____
Mental/Emotional Illness _____
Arthritis _____