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:_____

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Patient Name: _____

Please check "Yes" or "No" to indicate if you have had any of the following problems:

YES	NO	NATURE OF PROBLEM	COMMENTS AND GIVE APPROXIMATE DATE
		Recent Weight Loss	
		Headaches	
		Trouble with Hearing/Vision	
		Allergies/Hay Fever	
		Asthma	
		Thyroid	
		Diabetes	
		Skin	
		Anemia	
		Heart	
		Mitral Valve Prolapse/Heart Murmur	
		Chest Pain	
		High Blood Pressure	
		Circulation	
		Swelling in Feet or Ankles	
		Lungs (Pneumonia, TB, etc.)	
		Shortness of Breath(Cough, Pleurisy, Wheezing)	
		Liver Disease, Gall Bladder Disease or Jaundice	
		Stomach Trouble	
		Arthritis	
		Gout	
		Kidney Disease or Stones	
		Cancer	
		Bleeding Tendency	
		Scarring Tendency	
		Joint Pain or Stiffness	
		Numbness in Feet or Legs	
		Cramps in Feet or Legs	
		Low Back Pain	
		Sleep Apnea	
		If Yes, was this confirmed with a sleep study?	Date:
		If Yes, do you use a CPAP machine?	
		Psychiatric	

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Patient Name: _____

YES	NO	NATURE OF PROBLEM	COMMENTS/APPROXIMATE DATE
		Fainting or Convulsions	
		Strokes	
		HIV positive	
		Pain in Other Areas	
		Other Illnesses or Problems	
		Do you drink alcohol? How much?	
		Do you take any other drugs, either legal or illegal?	

Please give detail of any:

OPERATIONS/SERIOUS INJURIES	APPROX. DATE	PHYSICIAN	HOSPITAL

7. Have you had physical therapy? When? Where? For what condition? _____
_____
_____

8. Is there anything you wish to tell the doctor privately? Yes_____ No_____

Additional Information: _____
_____
_____
_____
_____

Patient Signature_____ Date_____

Witness_____ Date_____

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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

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MEDICAL HISTORY – Patient Name: _____

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

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

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EXERCISE SURVEY

1. **NAME:**_____

2. **AGE:** _____

3. **ACTIVITIES/EXERCISES DONE REGULARLY:** _____

   _____

   _____

4. **FREQUENCY OF ABOVE ACTIVITIES:** _____

   _____

5. **DO YOU USE PADS, ARCH SUPPORTS, OR ORTHOTICS NOW?**

   YES NO WHICH? : _____

6. **WHAT IS THE LONGEST PERIOD OF REST FROM EXERCISE YOU HAVE HAD IN THE LAST YEAR? :** _____

7. **WHAT ARE YOUR SHORT TERM AND LONG TERM GOALS?**

   _____

   _____

   _____

   _____

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Practice Expectations on Patient Needs

Patient Name: _____

To support all patient needs, we ask that patients review this list of items and agree to adhere to these responsiblities.

1. Prescription refills should be requested via a phone call or Webview request. We will call in or ePrescibe depending on drug. Patients should request these refills allowing for a 48 hour turn around time before its needed.
2. Patient should not show up at the office without an appointment expecting help from staff. If you are having an issue, please contact the office for a call back with a timeslot that works for the staff to help you.
3. Patients needing FMLA paperwork filled out, should have the paperwork faxed or should drop it off at the office. We need 2-3 business days to gather information and fill out the paperwork.
4. Request of record release to another doctors office should be done understanding the support for this request could take up to one week.
5. We use the phone number(s) on your patient paperwork to contact you for orthotics pick-up, questions about your insurance, etc. It is your responsibility to make sure we have the correct number to use for these situations.
6. If you cannot make your scheduled appointment, we ask for a minimum of 24 hours notice so we can use that appointment for another patient. If you fail to cancel your appointment greater than 24 hours in advance, there will be a $50 charge that must be paid before we will schedule you for another appointment. This charge is not covered by insurance and must be paid by the patient. If you have 3 no shows or cancellations, we reserve the right to not schedule you for another appointment.
7. We understand that situations result in patients being late but we reserve the right to reschedule you if you are more than 5 minutes late. This allows us to see all patients within their scheduled time.

Signature: _____ **Date:** _____
(Patient, Parent or Legal Guardian)