PATIENT REGISTRATION

POPLAR PODIATRY, P.C.
Dr. David G. Shainberg
Dr. Adam B. Libby
993 Reddoch Cove
Memphis, TN 38119
(901) 681 – 9141
Fax: (901) 681 – 9149

Patient Information

Name: _____,_____ __
Last First MI

Address: _____
Street

_____ _____ _____
City State Zip + 4

_____ _____
Home Phone Mobile Phone

E-mail: _____

Date of Birth: ____ / ____ / ____ Age: _____

SSN: _____ - _____ - _____

Sex: M F Marital Status: S M D W

Name of Spouse: _____

_____ _____
Emergency Contact Name Emergency Contact Phone

Whom may we thank for referring you to our office?

_____

My Primary Care Physician (Family Doctor) is:

_____

Patient's Employer

Employer: _____

Occupation: _____

Address: _____

City _____ State _____ Zip+4 _____

Work Phone: _____

Primary Insurance Company:_____

Secondary Insurance Company:_____

Please present Medical Insurance cards to receptionist.

Patient's Spouse/Guardian/Guarantor

Name: _____

Address: _____

City: _____ State ____ Zip+4 _____

Primary/Mobile Phone: _____

Work Phone: _____

SSN: ____ - ___ - ____ Date of Birth:___/___/___

Spouse/Guardian/Guarantor's Employer:

_____

Occupation: _____

Address: _____

_____

Phone: _____

Assignment of Benefits

I hereby authorize the verification of my medical benefits and payments directly to the treating physician. I understand that I am responsible for any portion of my bill not covered by my insurance company.

_____ ___ / ___ / ___
Signature Date

Release of Information

I hereby authorize the treating physician to release any information required in the course of my treatment to my insurance company.

_____ ___ / ___ / ___
Signature Date

Authorization of Medical Treatment

I hereby consent and authorize the physician and any associates or assistants or consultants of his/her choice to provide medical treatment for the above patient.

_____ ___ / ___ / ___
Signature Date

POPLAR PODIATRY, P.C.

993 Reddoch Cove, Memphis, TN 38119

Dr. David G. Shainberg ~ Dr. Adam B. Libby

FULL NAME:

Mr. / Dr. / Miss / Ms. / Mrs. _____ Age: _____ Date: _____

MEDICAL HISTORY

Do you HAVE or HAVE YOU HAD any of the following conditions?

	YES	NO		YES	NO
Diabetes	____	____	Blood clots (phlebitis)	____	____
Heart disease	____	____	Stomach disorder	____	____
High blood pressure	____	____	Seizures or epilepsy	____	____
Poor circulation	____	____	Abnormal or excessive bleeding	____	____
Arthritis	____	____	Difficulty healing	____	____
Kidney disease	____	____	Keloid or Thickened scars	____	____
Asthma	____	____	Gout	____	____
Stroke	____	____	Swollen feet or ankles	____	____
Rheumatic fever	____	____	HIV positive	____	____
Hepatitis or liver disease	____	____	Cancer: _____	____	____
Sickle cell trait	____	____			
Sickle cell anemia	____	____	Other condition(s) not listed: _____		

Do you have any ALLERGIES to any of the following?

	YES	NO	SENSITIVITY		YES	NO	SENSITIVITY
Codeine	____	____	____	Adhesive tape	____	____	____
Demerol	____	____	____	Local anesthetic	____	____	____
Penicillin	____	____	____	Iodine Solution	____	____	____
Sulfa	____	____	____	Other drug allergies: _____			

List ALL MEDICATION, including herbal products, you are currently taking: _____

_____

List Dates and Types of SURGICAL PROCEDURES you have had: _____

_____

Do you Smoke? YES / NO How much? _____ / day

Weight: _____ lbs. Height: ___' ___" Shoe Size: _____

Have you had Previous Care by Another Doctor for your feet? YES / NO

If you are 65 years or older, have you done any Advanced Care Planning such as an Advance Directive or Healthcare Power of Attorney? YES / NO

What Is The Reason For Today's Visit? _____

X_____

Signature of Patient/Responsible Party