Steven A. Hartung, DPM
1431 Washington Blvd
Williamsport, PA 17701
Phone: 570-323-7848
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Patient Name_____ **Date of Birth** _____
Social Security Number_____-_____-_____ Age_____ Sex: Male Female

Home Address_____
Street Address City State Zip Code

Phone: Home (_____) _____-_____ Work (_____) _____-_____ Cell (_____) _____-_____
Parent/Guardian if Minor _____
Contact Phone: (____) _____-_____ Relationship_____

Occupation _____ Employer _____ Phone (_____) _____-_____
Employer Address_____
Street Address City State Zip
Spouse_____ Employer_____ Phone (_____) _____-_____
Emergency Contact/ Relationship_____ Phone (_____) _____-_____

Primary Care Physician_____ Referring Physician _____

Reason for Today's Visit_____

How long has this problem existed? _____
Previous Treatment: _____
_____

Are you pregnant? No Yes

INSURANCE INFORMATION

Primary Insurance_____ Effective Date _____
Guarantor: (Who carries this insurance?) _____ DOB _____
If someone other than patient: Relationship _____ ID# _____
Secondary Insurance _____Effective Date _____
Guarantor: (Who carries the insurance?) _____DOB_____
If someone other than patient: Relationship _____ ID#_____

Privacy Practice

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

I request that payment of authorized Medicare/Other insurance company benefits are made on my behalf to Steven A. Hartung, DPM furnished by that party who accepts assignment. Regulation pertaining to Medicare assignment of benefits.

I authorize any holder of Medicare or other information about me to release to the Social Security Administration and Health Care Administration or its intermediaries or carrier or any other insurance company any information needed for this or related Medical Insurance Company claims.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim of the HCFA-1500 claim form. My signature authorizes releasing of the information to the insurer or agency Medicare/Other Insurance Company assigned cases, the physician or supplier agrees to accept the charge determination of the Medical Insurance Company as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. These fees are based upon the charge determination of the Medicare/other Insurance Company.

I understand that I am responsible for the payment **NOT** covered by my Insurance Company.
PATIENT SIGNATURE_____ Date_____

Patient Name: _____ Date: _____ DOB: _____

Height: _____ Weight: _____
Last Blood Pressure: _____ Flu Immunization: Yes____ No____

Please list any pertinent Medical History:

_____

Borderline/Pre or Diet Controlled Diabetic_____

Diabetes (Insulin) No Yes Diabetes (pills) No Yes How long? _____
How long? _____ Neuropathy (numbness or tingling feet) No Yes

Please circle yes or no

Heart Disease	No	Yes	Gout	No	Yes
Heart Attack	No	Yes	Varicose	No	Yes
Heart Failure	No	Yes	Leg Pain at Rest	No	Yes
High Blood Pressure	No	Yes	Leg Pain at Night	No	Yes
High Cholesterol	No	Yes	Pain when Walking	No	Yes
Chest Pain/ Palpitations	No	Yes	Leg Cramps	No	Yes
Irregular Heart Beat	No	Yes	Leg Swelling	No	Yes
Pacemaker	No	Yes	Bleeding Problems	No	Yes
Blood Clot	No	Yes	Clotting Problems	No	Yes
Phlebitis	No	Yes	Stroke	No	Yes
History of Ulceration	No	Yes	History of Seizures	No	Yes
Amputations/ Infections	No	Yes	Difficulty Healing	No	Yes

Tuberculosis	No	Yes	Hepatitis	No	Yes
HIV	No	Yes	MRSA	No	Yes

Unsteady Walking	No	Yes	Wheel Chair	No	Yes
Cane	No	Yes	Motorized Chair	No	Yes
Walker	No	Yes	Bed Bound	No	Yes

Past Medical History:
Please check if you have had or currently have the following:

Cancer (type) _____ Date_____ Treatment_____

Surgical History: Please list all past surgeries (most recent first)

_____

_____

Family History:
Please check if there is a family history of any of the following.

Diabetes	No	Yes	Cancer	No	Yes
Heart Attack	No	Yes	Aneurysm	No	Yes
Stroke	No	Yes			

Patient Name_____ Date_____ DOB_____

Social History:
Please answer the following questions:
Do you smoke? ___No ___Yes _____packs for ____ years When did you quit? _____
Do you drink alcohol __No ___Yes How much? _____
Do you take recreational drugs? __No ___Yes (List) _____
Whom do you live with? ___Alone ____Spouse Other_____
Are you currently employed? __No ___Yes (What kind of work do you do?) _____
__Retired (What kind of work did you do?)_____

Review of Systems:
Please circle yes or no for the following:

Weight Loss	No	Yes	Pain with BM/ Urination	No	Yes
Headaches/ Vision Change	No	Yes	Stomach Pain/ Reflux	No	Yes
Cough/Hoarseness	No	Yes	Kidney Failure	No	Yes
Nausea/ Vomiting	No	Yes	Dialysis	No	Yes
Chills/ Night Sweats	No	Yes	Urinary Incontinence	No	Yes
Decreased Appetite	No	Yes	Bowel Problems	No	Yes
Thyroid Problem	No	Yes	Blood in Stool/ Urine	No	Yes
Blindness	No	Yes	Weakness/ Tremor	No	Yes
Poor Vision	No	Yes	Back Pain	No	Yes
Hearing Loss R/L	No	Yes	Pain with Walking	No	Yes
Deafness R/L	No	Yes	Loss of Foot Function	No	Yes
Difficulty Swallowing	No	Yes	Leg/ Foot Ulcers	No	Yes
Shortness of Breath	No	Yes	Numbness/ Tingling	No	Yes
Phlebitis/ Varicose Veins	No	Yes	Heat/ Cold Intolerance	No	Yes
Calf Pain with Walking	No	Yes	Skin Rashes/ Bruises	No	Yes
Leg Cramping	No	Yes	Leg/ Foot Swelling	No	Yes
Chest Pain	No	Yes	Bleeding Tendency	No	Yes
GERD	No	Yes	Fatigue	No	Yes
Diarrhea	No	Yes	Emphysema	No	Yes
Constipation	No	Yes	Asthma	No	Yes
Abdominal Pain	No	Yes	COPD	No	Yes

Medications:
Please provide a list of all current medications, including over-the-counter medications you are currently taking.

_____

_____

Allergies: Please list any allergies or reactions to food, medications, radiographic dye

_____

_____

Pharmacy: _____ Telephone: _____

Yes I hereby give Dr. Hartung permission to examine and treat my lower extremities.
Signature_____ Date_____