

Dankmeyer, Inc.

825 N Hammonds Ferry Road Ste D
Linthicum, MD 21090-1355

Tel: (410) 636-8114
Fax: (410) 636-8325

PATIENT INFORMATION			
PATIENT NAME	LAST	FIRST	MI
			TITLE: <input type="checkbox"/> DR <input type="checkbox"/> MR <input type="checkbox"/> MRS <input type="checkbox"/> MS <input type="checkbox"/> MISS
EMAIL ADDRESS			IS IT OK TO CONTACT YOU BY EMAIL? <input type="checkbox"/> YES <input type="checkbox"/> NO
DATE OF BIRTH			
SOCIAL SECURITY NUMBER			
DRIVERS LICENSE NUMBER			
MARITAL STATUS	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED		
PHONE NUMBERS	HOME () WORK () CELL ()	OK TO LEAVE A MESSAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO OK TO LEAVE A MESSAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO OK TO LEAVE A MESSAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
HOME ADDRESS			
EMPLOYMENT STATUS	<input type="checkbox"/> DISABLED – IF DISABLED SEE PAGE 3 <input type="checkbox"/> FULL TIME EMPLOYED <input type="checkbox"/> PART TIME EMPLOYED <input type="checkbox"/> RETIRED <input type="checkbox"/> UNEMPLOYED <input type="checkbox"/> FULL TIME STUDENT <input type="checkbox"/> PART TIME STUDENT		
EMPLOYER (OR PREVIOUS IF RETIRED)			
EMPLOYERS ADDRESS			

EMERGENCY CONTACT	
CONTACT NAME	RELATIONSHIP:
CONTACT ADDRESS	
CONTACT PHONE	
CONTACT EMAIL	

PHYSICIAN	
REFERRING PHYSICIAN	PHONE:
PRIMARY CARE PHYSICIAN	PHONE:

HOW WERE YOU REFERRED TO DANKMEYER?

POWER OF ATTORNEY (if applicable)

NAME		RELATIONSHIP:
CONTACT INFORMATION:		
	<input type="checkbox"/> MEDICAL <input type="checkbox"/> FINANCIAL <input type="checkbox"/> BOTH	

IS PATIENT SELF PAY?	<input type="checkbox"/> YES <input type="checkbox"/> NO
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WORKERS COMPENSATION/LIABILITY INSURANCE

INSURANCE COMPANY NAME			
CLAIM NUMBER		DATE OF INJURY:	STATE:
CONTACT PERSON		CONTACT PERSON'S PHONE:	
INSURANCE COMPANY ADDRESS			
NAME OF EMPLOYER		IS THIS THROUGH: <input type="checkbox"/> EMPLOYER <input type="checkbox"/> INDIVIDUAL	IS POLICY HOLDER STILL WORKING? <input type="checkbox"/> YES <input type="checkbox"/> NO

PRIMARY INSURANCE

INSURANCE COMPANY NAME			
INSURANCE ID NUMBER		GROUP NUMBER:	PLAN NUMBER:
SUBSCRIBER INFORMATION	SUBSCRIBER NAME:		RELATIONSHIP TO SUBSCRIBER:
	SUBSCRIBER DATE OF BIRTH:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	SUBSCRIBER SOCIAL SECURITY NUMBER:
SUBSCRIBER ADDRESS			
SUBSCRIBER PHONE			
SUBSCRIBER EMPLOYER			

SECONDARY INSURANCE

INSURANCE COMPANY NAME			
INSURANCE ID NUMBER		GROUP NUMBER:	PLAN NUMBER:
SUBSCRIBER INFORMATION	SUBSCRIBER NAME:		RELATIONSHIP TO SUBSCRIBER:
	SUBSCRIBER DATE OF BIRTH:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	SUBSCRIBER SOCIAL SECURITY NUMBER:
SUBSCRIBER ADDRESS			
SUBSCRIBER PHONE			
SUBSCRIBER EMPLOYER			

TERTIARY INSURANCE			
INSURANCE COMPANY NAME			
INSURANCE ID NUMBER		GROUP NUMBER:	PLAN NUMBER:
SUBSCRIBER INFORMATION	SUBSCRIBER NAME:		RELATIONSHIP TO SUBSCRIBER:
	SUBSCRIBER DATE OF BIRTH:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	SUBSCRIBER SOCIAL SECURITY NUMBER:
SUBSCRIBER ADDRESS			
SUBSCRIBER PHONE			
SUBSCRIBER EMPLOYER			

DISABILITY INFORMATION	
HAS THE PATIENT APPLIED TO SOCIAL SECURITY FOR DISABILITY BENEFITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
IF YES, WERE YOU APPROVED? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF APPROVED, AS OF WHAT DATE?

BY SIGNING THIS FORM, YOU ARE VERIFYING THAT THE INFORMATION ABOVE IS ACCURATE TO THE BEST OF YOUR KNOWLEDGE.

_____ DATE

_____ PRINTED NAME OF PATIENT OR GUARDIAN

ASSIGNMENT OF BENEFITS/MEDICAL RECORDS RELEASE

I authorize the release of all medical records to and from my insurance company and to and from my referring and primary healthcare providers, if applicable.

I understand that it is my responsibility to provide Dankmeyer, Inc. with referrals, prescriptions and information required by my insurance.

I request that payment of authorized medical benefits (including Medicare and other third-party payers) be made either to me or to Dankmeyer, Inc. on my behalf, for any services furnished to me by Dankmeyer, Inc. I authorize any holder of medical or other information about me to release that information as required to Dankmeyer, Inc. to coordinate my medical benefits.

It is my responsibility to inform Dankmeyer, Inc. of any changes to my insurance or other information as they occur.

I understand that payment for services provided is due at the time of service unless other financial arrangements have been made.

I acknowledge full financial responsibility for all services provided to me by Dankmeyer, Inc.

SIGNATURE

DATE

PRINTED NAME

RELATIONSHIP TO PATIENT

BENEFICIARY NAME

HICN MEDICARE NUMBER

**PATIENT CONSENT TO USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

Dankmeyer, Inc. obtains and maintains health information relating to my past, present or future physical or mental condition; provision of health care or payment for health care; referred to as "Protected Health Information." This Protected Health Information may be used or disclosed by Dankmeyer, Inc. for the purposes of treatment, payment or health care operations, including, but not limited to:

- Planning for my care and treatment;
- Contacting me with appointment reminders and results;
- Submitting a claim to my insurer or health plan; and
- Assessing the quality of care provided to me.

Dankmeyer Inc.'s Notice of Privacy Practices contains a more complete description of how my Protected Health Information may be used and disclosed and how I can obtain access to this information, whether it be in electronic or hard copy format. I understand that Dankmeyer, Inc. reserves the right to change its Notice and practices and I can request a copy of its current Notice.

I understand that I have the right to request restrictions as to how my Protected Health Information may be used or disclosed by Dankmeyer, Inc. This includes the right to restrict disclosure of encounter information to an insurer if services are paid fully out of pocket. Dankmeyer, Inc. is not required to agree to my request but if it does agree, the requested restrictions will be binding.

I understand that at any time, I may revoke this consent in writing, except to the extent that Dankmeyer, Inc. has already taken action in reliance on it.

I understand that I have the right to be notified in the event of a breach of privacy or security of my Protected Health Information.

By signing this form below, I consent to Dankmeyer, Inc.'s use and disclosure of my Protected Health Information for the purposes of treatment, payment and/or health care operations and acknowledge receipt of Dankmeyer, Inc.'s Notice of Privacy Practices.

SIGNATURE

DATE

PRINTED NAME

RELATIONSHIP TO PATIENT

If executed by Legal Representative, please describe relationship to patient:

WITNESS

DATE

PATIENT CONSENT FOR MEDICAL PHOTOGRAPHY

PATIENT NAME: _____ DATE: _____

I consent for medical photographs to be made of me or my child (or person for whom I am legal guardian). I understand that the information may be used in my medical record, for purposes of medical teaching, or for publication in medical textbooks or journals as I have designated below. By consenting to these medical photographs I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future, I may contact Mark Hopkins at 410-636-8114.

By signing this form below, I confirm that this consent form has been explained to me in terms which I understand.

1. I consent for these photographs to be used in medical publications, including medical journals, textbooks, electronic publications, and grant applications. I understand that the image may be seen by members of the general public, in addition to scientists and medical researchers that regularly use these publications in their professional education. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. I also agree for my image to be shown for teaching purposes and to be used for my medical record.

SIGNATURE

PRINTED NAME

RELATIONSHIP TO PATIENT

WITNESS

2. I agree for my image to be shown for teaching purposes AND to be used for my medical record, but NOT for medical publication.

SIGNATURE

PRINTED NAME

RELATIONSHIP TO PATIENT

WITNESS

3. I agree to use of my image for medical records ONLY.

SIGNATURE

PRINTED NAME

RELATIONSHIP TO PATIENT

WITNESS

FOR PATIENTS BETWEEN AGES 7 AND 18 YEARS, A SIGNATURE BELOW INDICATES THAT THE INFORMATION IN THIS CONSENT FORM HAS BEEN EXPLAINED TO ME AND I ASSENT TO USE OF MY IMAGES AS OUTLINED ABOVE.

SIGNATURE

PRINTED NAME

RELATIONSHIP TO PATIENT

WITNESS

DANKMEYER

PROSTHETICS & ORTHOTICS

TODAY'S DATE

PATIENT NAME:

HOW DID YOU HEAR ABOUT US?

- FACEBOOK FRIEND WEBSITE PATIENT OTHER _____
 PHYSICIAN _____ THERAPIST _____

HEIGHT:

WEIGHT:

MEDICAL CONDITIONS: (Check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> ALZHEIMERS OR DEMENTIA | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> OSTEOPOROSIS |
| <input type="checkbox"/> ANXIETY | <input type="checkbox"/> HIV | <input type="checkbox"/> PARKINSON'S DISEASE |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> INFECTIONS | <input type="checkbox"/> PULMONARY DISEASE (TB) |
| <input type="checkbox"/> BRAIN INJURY/TBI | <input type="checkbox"/> INTESTINAL PROBLEMS | <input type="checkbox"/> RHEUMATOID ARTHRITIS |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> SEIZURE DISORDER |
| <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> LIVER DISEASE | <input type="checkbox"/> SKIN PROBLEMS |
| <input type="checkbox"/> DIABETES TYPE I | <input type="checkbox"/> MIGRAINES | <input type="checkbox"/> STOMACH PROBLEM |
| <input type="checkbox"/> DIABETES TYPE II | <input type="checkbox"/> MRSA | <input type="checkbox"/> STROKE/TIA/CVA |
| <input type="checkbox"/> HEARING LOSS | <input type="checkbox"/> NEUROLOGIC PROBLEMS | <input type="checkbox"/> VASCULAR DISEASE |
| <input type="checkbox"/> HEART PROBLEMS | <input type="checkbox"/> OBESITY | <input type="checkbox"/> VISION PROBLEMS |
| <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> OSTEOARTHRITIS | |
| <input type="checkbox"/> OTHER CONDITION: | | |

PAST SURGICAL HISTORY:

	SURGERIES	APPROXIMATE DATE
1.		
2.		
3.		

DO YOU HAVE ALLERGIES TO MATERIALS OR ADHESIVES? YES NO

HAVE YOU FALLEN IN THE LAST 6 MONTHS? YES NO

HAVE YOU RECEIVED AN ARTIFICIAL LIMB OR BRACE IN THE LAST 5 YEARS? YES NO

*WHERE DID YOU RECEIVE IT FROM?

OCCUPATION:

- EMPLOYED FULL TIME ON DISABILITY, SINCE _____ FULL TIME STUDENT
 EMPLOYED PART TIME RETIRED UNEMPLOYED
 HOMEMAKER

DO YOU USE ANY OF THESE DEVICES?

- NONE WALKER SCOOTER
 CANE MANUAL WHEELCHAIR SHOWER CHAIR
 CRUTCHES POWER WHEELCHAIR STAIR LIFT

PLEASE LIST THREE ACTIVITIES/HOBBIES YOU PERFORM THROUGHOUT THE WEEK:

1.

2.

3.

DANKMEYER

PROSTHETICS & ORTHOTICS

Patient Contact Confidentiality

Patient Name: _____ ID#: _____ DOB: _____

PERSONAL INFORMATION

I authorize the release of information regarding my medical care, appointments, and transportation (if applicable) to:

Spouse's Name: _____

Child(ren)'s Name(s): _____

Other Name: _____ Relationship: _____

I authorize the release of financial information regarding my medical care to:

Spouse's Name: _____

Child(ren)'s Name(s): _____

Other Name: _____ Relationship: _____

I do not authorize the release of my information to anyone else.

PRIMARY PHONE CONTACT & WHERE TO LEAVE A MESSAGE

Please call Home # _____ Work# _____ Cell # _____

If unable to reach me:

Leave a detailed message on voicemail

Leave a detailed message with person answering the phone

Leave a non-detailed message only asking for a return call (either on voice mail or with a person)

Other _____

EMAIL

I authorize correspondence regarding my medical care via email address _____

I do not wish to be contacted via email.

Signature _____ Date: _____

I may make changes to this information at any time in writing.

DANKMEYER
PROSTHETICS & ORTHOTICS

Patient Contact Confidentiality – Responsible Party

Patient Name: _____ ID#: _____ DOB: _____

PERSONAL INFORMATION

I authorize the release of information regarding the above patient’s medical care, appointments, and transportation (if applicable) to:

Name: _____ Relationship: _____

I do not authorize the release of information to anyone else.

I authorize the release of financial information regarding the above patient’s medical care to:

Name: _____ Relationship: _____

I do not authorize the release of information to anyone else.

PRIMARY PHONE CONTACT & WHERE TO LEAVE A MESSAGE

Please call Home # _____ Work# _____ Cell # _____

If unable to reach me:

Leave a detailed message on voicemail

Leave a detailed message with person answering the phone

Leave a non-detailed message only asking for a return call (either on voice mail or with a person)

Other _____

EMAIL

I authorize correspondence regarding the above patient’s medical care via email address _____

I do not wish to be contacted via email.

Signature _____ Date: _____

Printed Name _____ Relationship: _____

I may make changes to this information at any time in writing.