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:** ☐ DR ☐ MR ☐ MRS ☐ MS ☐ MISS
EMAIL ADDRESS				IS IT OK TO CONTACT YOU BY EMAIL? ☐ YES ☐ NO
DATE OF BIRTH				
SOCIAL SECURITY NUMBER				
DRIVERS LICENSE NUMBER				
MARITAL STATUS	☐ SINGLE	☐ MARRIED	☐ DIVORCED	☐ WIDOWED
PHONE NUMBERS	HOME ( )		OK TO LEAVE A MESSAGE? ☐ YES ☐ NO	
	WORK ( )		OK TO LEAVE A MESSAGE? ☐ YES ☐ NO	
	CELL ( )		OK TO LEAVE A MESSAGE? ☐ YES ☐ NO	
HOME ADDRESS				
EMPLOYMENT STATUS	☐ DISABLED – *IF DISABLED SEE PAGE 3*			
	☐ FULL TIME EMPLOYED	☐ PART TIME EMPLOYED	☐ RETIRED	
	☐ UNEMPLOYED	☐ FULL TIME STUDENT	☐ 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:		
	☐ MEDICAL ☐ FINANCIAL ☐ BOTH	

IS PATIENT SELF PAY?	☐ YES ☐ NO

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: ☐ EMPLOYER ☐ INDIVIDUAL	IS POLICY HOLDER STILL WORKING? ☐ YES ☐ 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: ☐ MALE ☐ 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: ☐ MALE ☐ 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: ☐ MALE ☐ FEMALE	SUBSCRIBER SOCIAL SECURITY NUMBER:	
SUBSCRIBER ADDRESS				
SUBSCRIBER PHONE				
SUBSCRIBER EMPLOYER				

DISABILITY INFORMATION	
HAS THE PATIENT APPLIED TO SOCIAL SECURITY FOR DISABILITY BENEFITS? ☐ YES ☐ NO	
IF YES, WERE YOU APPROVED? ☐ YES ☐ 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

NAME: _____ DATE: _____ HEIGHT: _____ WEIGHT: _____

1. What brings you into our office today? _____
   _____

2. Do you currently have a brace or prosthesis? ☐ Yes ☐ No
   a. If so, when did you receive it? _____
   b. Was it provided by Dankmeyer? ☐ Yes ☐ No
      i. If it was not provided by Dankmeyer, who provided it? _____
   c. How often do you wear your device?
      i. _____ days per week
      ii. _____ hours per day

3. What assistive devices do you use? Check all that apply.
   In your home: ☐ none ☐ cane ☐ crutches ☐ walker ☐ manual wheelchair
   ☐ scooter ☐ electric wheelchair ☐ shower chair ☐ stair lift

   In the community: ☐ none ☐ cane ☐ crutches ☐ walker ☐ manual wheelchair
   ☐ scooter ☐ electric wheelchair

4. Do you encounter steps/stairs on a daily basis? ☐ Yes ☐ No

5. If employed, what is your occupation: _____

6. What are some hobbies and/or activities you enjoy doing? _____

7. Please list some goals you would like to accomplish with your new device: _____
   _____

8. Regarding your medical history, please check all that apply:
   ☐ Heart Problems ☐ Hepatitis A or B ☐ Vision Problems ☐ Pacemaker
   ☐ Hypertension ☐ Hepatitis C ☐ Parkinson Disease ☐ Seizure Disorder
   ☐ Vascular Disease ☐ HIV positive ☐ Alzheimer Disease ☐ Hearing Loss
   ☐ Stroke ☐ Rheumatoid Arthritis ☐ Depression ☐ Drug Abuse
   ☐ Diabetes ☐ Osteoarthritis ☐ Alcoholism ☐ MRSA
   ☐ Kidney Disease ☐ COPD ☐ Material/Contact Allergies
   ☐ Osteoporosis ☐ Pulmonary Disease (TB)
   ☐ Other: _____
   ☐ Surgeries: _____

9. What medications are you currently taking? _____

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www.dankmeyer.com

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.

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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.

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