DANKMEYER
PROSTHETICS & ORTHOTICS

Patient Information Form

Last Name:_________________________**First Name:**_________________**MI:**______**Date of Birth:** ____________

Age:_____________**Male or Female:**_____________**Social Security #:**____________________________________

Home Address: ____

Street *City* *State* *Zip*

Home Phone:_____________________**Cell Phone:**___________________**Work Phone:**_______________________

Email Address: _______________________________ ☐ I authorize correspondence regarding my medical care via email

Employment: ☐ **Full-time** ☐ **Part-time** **Marital Status:** ☐ **Married** ☐ **Single**

☐ **Retired** ☐ **Unemployed** ☐ **Widowed** ☐ **Divorced**

Employer Name: ____

Referring Doctor: ____ Phone #___________________________________

Primary Care Physician: ____________________________________ Phone #___________________________________

Primary Insurance

Insurance Co: ___________________________**Member ID#**____________________________**Group#**___________

Subscribers Name:__________________________________**SS#**_________________________**DOB:**______________

Phone:________________________**Relationship to Patient:** _______________**Employer:**_____________________

Address if Different than Patient:

____

Street *City* *State* *Zip*

Secondary Insurance

Insurance Co:__________________**Member ID #**_________________________**Group #**________________________

Subscribers Name:_______________________________**SS#**___________________________**DOB:**______________

Phone: ________________________ **Relationship to Patient:** _______________**Employer:**______________________

Address if Different than Patient:

____

Street *City* *State* *Zip*

Do you have any other insurance not listed above? ☐ **Yes**, if so provide info to the front desk ☐ **No**

Workman Compensation/Liability Insurance

Insurance Company Name:_______________________________________ **Claim #**_______________________

Date of Injury:____________________________ **State Injury Occurred:**_______________________________

Contact Person:____________________________ **Contact Person's Phone #:**__________________________

Insurance Company Address: ____
Street *City* *State* *Zip*

Name of Employer: ____
Is this through: ☐ **Employer** ☐ **Individual** **Is the Policy Holder Still Working:** ☐ **Yes** ☐ **No**

Emergency Contact (EC) / Release of Information (ROI)

Please Check the Boxes that Apply: Name of Person to Contact in case of Emergency/or we may release information to:

Name:_______________________ **Phone:**_______________________ **Relationship:**___________ ☐ **EC** ☐ **ROI**

Name:_______________________ **Phone:**_______________________ **Relationship:**___________ ☐ **EC** ☐ **ROI**

Name:_______________________ **Phone:**_______________________ **Relationship:**___________ ☐ **EC** ☐ **ROI**

Communication: ☐ A detailed message may be left on answering machine
☐ A non-detailed message may be left on answering machine
☐ Message may be left with person/persons listed above
☐ I do not release my information to anyone

Power of Attorney? ☐ **N** ☐ **Y**

(If yes) Name:_______________________ **Phone:**_____________________ **Relationship:**___________________

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?** _______________

Print your name: _______________________ **Signature:**______________________________ **Date:**_____________

By signing this form, you are verifying that the information above is accurate to the best of your knowledge.

NOTICE OF CONFIDENTIALITY: This document contains unconditionally private medical records. Any improper use of the information contained herein constitutes a breach of patient medical confidentiality.

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.

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 the date of service used to bill to my insurance will be at completion of the service and/or delivery of the device.
- 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	MBI (Medicare Beneficiary #)	WITNESS	DATE