

Eckardt Johanning, M.D., M.Sc.

Occupational and Environmental Life Science -
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Patient Information & Consent

Offices:
Albany,
New York City
Frankfurt/Main, FRG

Date: _____

Name: _____ DOB: ____/____/____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone #: (home) (____) _____ (work) (____) _____

Cellular Phone #: (____) _____ Fax # _____

Employer: _____

Insurance: _____ Insured's Name: _____

Policy/Group #: _____ Insured's Date of Birth: ____/____/____

Relationship to Insured: Self ___ Spouse ___ Child ___ Other ___

Is condition related to employment: yes ___ no ___ If yes, please furnish the:

Worker's Compensation #: _____ Date of Accident: _____

Consent

I herewith consent to medical evaluation and treatment by Dr. Eckardt Johanning or his associates. I consent that anonymous health data or lab results may be used for medical research and education. I hereby assign to Dr. Eckardt Johanning, where applicable all payment for medical services, even if he does not accept assignment from my medical insurance company but not to exceed stated charges.

I hereby acknowledge that Dr. Johanning is not under any obligation to provide any legal testimony or testimony that is favorable to me or has not provided me with any assurances of a "positive" evaluation and/or testimony to support any legal claims. A photographic copy of this authorization shall be as valid as the original. I have also received a copy of the Notice of Privacy Practices.

Name
(Rev. 11/04)

City

State

Date

"is a member of"



AMERICAN COLLEGE OF
OCCUPATIONAL AND
ENVIRONMENTAL MEDICINE