DME EXCHANGE OF DALLAS

Recycling Durable Medical Equipment For Those In Need

DATE:_____ /_____/_____

Last Name:_____ **First Name**:_____ **Middle Init**:____

Physical Address:_____ **Apt #**:_____

City/State:_____ **Zip**:_____ **County**:_____

Phone: (_____) _____-_____ **Email**:_____

Alternate contact name and #_____**Relationship**_____

Mailing Address (if different from above) or 2nd contact number for client:

_____

Patient's height:_____**Patient's weight:**_____**Patient's preferred language:**_____

DOB: ___/___/____ **Age**:_____ **Sex**: M F **Social Security #**_____-_____-_____

Race: Caucasian African American Hispanic Asian/Pacific Native American Other

Are you a Veteran? Yes No

Insurance: None Medicare Medicaid Commercial Parkland Health Plus Other_____

Referring Physician/Hospital/Clinic/Social Worker/Agency:

_____

Their Contact #: (____) _____-_____**Name**_____

I certify that all information given in this application and supporting documents is correct to the best of my knowledge.

Client Signature:_____

STAFF ONLY:
Income Verified: Y / N (check stub, award letter copy provided and placed in chart)
Insurance Verified: Y/N (copy of coverage placed in chart and/ or medical social worker referral letter placed in chart)
Release of Information/ Liability Waiver signed: Y/N
Original DME Prescription: Y/N
Copy of ID: Y/N
Social Security number: Y/N
Staff member:
_____ **Date**:_____