**PATIENT REGISTRATION FORM**

**Provider (circle one):** Mark Oldendorf, MD Corina Gonzales, MD Michelle Cafaro, RPA

Jenna Hafner, PA-C Bill Lynch, PA-C

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number:\_\_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: (\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: (\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ Sex:\_\_\_\_\_\_\_\_\_ Marital Status: (circle one) S M D W

Race:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (optional) Ethnicity:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (optional)

Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Preferred Pharmacy:**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact:**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone:(\_\_\_\_\_\_)\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone:(\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is this visit related to a Worker’s Compensation or No Fault claim?: YES NO**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I request payment of authorized Medicare of any other insurance benefits directly to OLDENDORF MEDICAL SERVICES, PLLC. I acknowledge that I am financially responsible for any unpaid balances, including services not covered by my insurance carrier. I authorize the Practice to release to Medicare or other insurance carrier any information needed to determine these benefits or benefits for related services. I authorize the Practice to use or disclose my health information to treat my condition, obtain payment for that treatment and run business operations. The Practice may also disclose my health information for payment activities and certain business operations of another health care provider or payer.

I hereby voluntarily consent to medical care encompassing diagnostic procedures and medical treatment performed by my physician, his/her assistants consignees as may be necessary in his/her judgment. I acknowledge that no guarantees have been made as to the result of treatments or examination.

**Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE**

I understand and have been provided with a Notice of Privacy Practices that provides a description of how this medical practice may use and disclose my protected healthcare information. I further understand that the Practice reserves the right to change its Notice of Privacy Practices. Should the Practice change its Notice of Privacy Practices, an amended copy will be posted in a prominent location in the practice site.

**Please review the questions below and answer yes or no:**

Do you give us permission to **leave appointment** Do you give us permission to leave **medical information:**

**information:**

On home answering machine? Yes □ No □ On home answering machine? Yes □ No □

On cell phone voicemail? Yes □ No □ On cell phone voicemail? Yes □ No □

On cell phone text message? Yes □ No □ On cell phone text message? Yes □ No □

On work phone/voicemail? Yes □ No □ On work phone/voicemail? Yes □ No □

With another person? Yes □ No □ With another person? Yes □ No □

Sent via mail? Yes □ No □ Sent via mail? Yes □ No □

Sent via e-mail/Patient Portal Yes □ No □ Sent via e-mail/Patient Portal Yes □ No □

The names of others who may receive information about my medical care:

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient’s Name (PRINT) Date of Birth**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s Signature Date**

**Provider (please circle one):** Mark Oldendorf, MD Corina Gonzales, MD Michelle Cafaro, RPA Jenna Hafner, PA-C Bill Lynch, PA-C

When a patient is a minor, or is unable to give consent, the signature of a parent, guardian, or other representative is required.

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Patient Representative Date