Oldendorf Medical Services, PLLC
Mark Oldendorf, MD   Richard Balsam,
Michelle Gariepy RPA Cheryl Ernst, NP

PATIENT REGISTRATION FORM

Provider (please circle one): Mark Oldendorf, MD, Richard Balsam, MD, Michelle Gariepy, RPA, Cheryl Ernst, NP

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:**________________

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