Oldendorf Medical Services, PLLC
Mark Oldendorf, MD
Corina Gonzales, MD Hedy Migden, MD
Michelle Cafaro, RPA Jenna Hafner, PA-C William Kohler, RPA

PATIENT REGISTRATION FORM

Provider (circle one): Mark Oldendorf, MD Corina Gonzales, MD Michelle Cafaro, RPA Jenna Hafner, PA-C Hedy Migden, MD William Kohler, RPA

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)

Occupation: _____ 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:_____

407 Albany Shaker Road
Loudonville, NY 12211
Office: (518) 435-1300 Fax: (518) 435-1397

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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:

How do you want to receive appointment information:

On home answering machine? Yes ☐ No ☐

On cell phone voicemail? Yes ☐ No ☐

On cell phone text message? Yes ☐ No ☐

On work phone/voicemail? Yes ☐ No ☐

With person(s) listed below? Yes ☐ No ☐

Sent by mail? Yes ☐ No ☐

Sent by e-mail/Patient Portal Yes ☐ No ☐

How do you want to receive medical information:

On home answering machine? Yes ☐ No ☐

On cell phone voicemail? Yes ☐ No ☐

On cell phone text message? Yes ☐ No ☐

On work phone/voicemail? Yes ☐ No ☐

With person(s) listed below? Yes ☐ No ☐

Sent by mail? Yes ☐ No ☐

Sent by e-mail/Patient Portal Yes ☐ No ☐

Please list the names of others who may receive information about my appointments or my medical care:

Name:_____ Phone #:_____Relationship:_____

Name:_____ Phone #:_____Relationship:_____

Name:_____ Phone #:_____Relationship:_____

_____ _____

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

_____ _____

Patient's Signature **Date**

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

_____ _____

Patient Representative Date

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