Oldendorf Medical Services, PLLC
Mark Oldendorf, MD Hedy Migden, MD John Buddenhagen, DO
Sudeep Ross, MD Michelle Cafaro, PA-C Jenna Hafner, PA-C
Sara Buckley, PA-C Priscela Perez, PA-C

PATIENT REGISTRATION FORM

Provider (Circle One): Mark Oldendorf, MD Hedy Migden, MD John Buddenhagen, DO
Sudeep Ross, MD Michelle Cafaro, PA-C Jenna Hafner, PA-C
Sara Buckley, PA-C Priscela Perez, PA-C

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

Date of Birth: ____ /____ /_____ Sex (As Listed on Insurance): M F Sex at Birth: M F

Preferred Pronoun (Optional): □ He □ She □ They □ Other _____ Gender Identity (Optional): _____

Marital Status: □ Single □ Married □ Divorced □ Widowed

Race:
□ Black/African American
□ White
□ American Indian /Alaska Native
□ Asian
□ Native Hawaiian/Other Pacific Islander
□ Other _____
□ Decline to Specify/Unknown

Ethnicity:
□ Hispanic/Latino
□ Not Hispanic/Latino
□ Decline to Specify/Unknown

Occupation: _____ Email Address: _____

Preferred Lab Company: _____

Preferred Pharmacy: _____

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 or any other insurance benefits directly to OLDENDORF MEDICAL SERVICES, PLLC (Practice). 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, and their assistants/consignees as may be necessary in their 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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