JANET WESTENBERGER, D.O.
Westwood Medical Park
3875 North Buffalo Road, Orchard Park, NY 14127
PH: 716-662-9336 FX: 716-662-9236

Today's Date: _____ Sex: ☐ M ☐ F Age: _____ Birthdate: _____ ☐ Single ☐ Married ☐ Other: _____

Patient Name: _____
Last Name First Name Middle Initial

Home Address: _____ City _____ State _____ Zip _____

Home#: _____ Cell#: _____ Work#: _____ Best # to be reached: H - C - W

Email Address: (This is important so we can communicate with you through the patient portal): _____

Race: White - African American - Hispanic - Asian - Indian - Other: _____ Preferred Language: _____

Pharmacy Name, Address, Phone#: _____

Employer/School and Occupation: _____

Spouse: _____ Birthdate: _____

Spouse's Employer Name/Occupation: _____

Who is responsible for this account? _____ Relationship to patient: _____

Patient's Social Security #: _____ Spouse's Social Security #: _____

Do you have Medical Insurance? ☐ No ☐ Yes If yes,

Name of Insurance Carrier: _____ ID#: _____

Policy Holder Name: _____ DOB: _____ Group # _____

Name of Secondary Insurance (In Any): _____ ID#: _____

Policy Holder Name: _____ DOB: _____ Group # _____

In case of emergency, who should we notify? _____ Phone: _____

How did you learn of our practice? _____

Patient/Guardian Signature: _____ Date: _____

Authorizations

Insurance Assignment and Release

I certify that I have insurance coverage with _____
(Name of Insurance Company)
and assign directly to Dr. Janet Westenberger all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will not end unless I terminate Dr. Janet Westenberger as my doctor.

Medicare/ Medigap Authorization
I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to Dr. Janet Westenberger for any services furnished to me by Dr. Janet Westenberger and/or her office (staff).

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____ _____
(Signature of Beneficiary, Guardian or Personal Representative) (Date)

_____ _____
(Print Name of Beneficiary, Guardian or Personal Representative) (Relationship to Beneficiary)

HEALTH QUESTIONNAIRE

Please complete this questionnaire so that we can serve your health care needs. NOTE: This is the confidential information that will not be released to any person except when you have authorized us to do so. Please use the back side if you need more space.

Name: | **Age:** **Date of Birth:** | O Single O Divorced O Married O Widowed

Date of last Physical Exam: | **Birthplace:** | **Today's Date:**

Occupation:

List all medications, dose and frequency presently being taken (including birth control pills and vitamins)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Past Surgies/Hospilizations (give details- dates and reasons):

Last date of Tetanus:

Allergies (circle if allergic to any of the following)
Penicillin Bees/Wasps Other _____
Sulfa Codeine/Morphine Reaction:
Mycin Tetanus antitoxins
Aspirin Foods

Comments:

What kind of special diet do you follow?

Past Medical History/ Review of Systems

O Aids/HIV Disease
O Anemia or any bleeding disorder
O Any bone or Joint Disease
O Appendicitis
O Arthritis or Rheumatism
O Asthma
O Bladder disease or and Urinary Tract Disease
O Broken or Cracked Bones
O Bronchitis
O Bursitis, Siatica or Lumbago
O Cancer
O Chicken Pox
O Colitis or bowel disease
O Concussion
O Diabetes
O Diphtheria
O Dislocations
O Emphysema
O Epilepsy/ Seizures
O Food, Chemical or Drug Poisoning
O Frequent Infections or Boils
O Gallbladder Disease
O German Measles
O Glaucoma/ Cataracts
O Gonorrhea, Syphilis, Chlamydia or any other sexually transmitted disease
O Gout
O Hay Fever
O Heart Disease
O Hemorrhoids or any rectal disease
O Hepatitis or Jaundice
O High or Low Blood Pressure
O Hives or Eczema
O Influenza (flu)
O Lacerations
O Measles
O Migraine Headaches
O Mumps
O Nephritis or any other Kidney Disease
O Nervous Disorder or any other Psychiatric Disorder
O Neuritis or Neuralgia
O Pleurisy
O Pneumonia
O Polio or Meningitis
O Rheumatic Fever or Heart Disease
O Scarlet Fever or Scarlatina
O Skin Diseases
_____
O Small Pox
O Sprains/ Spasms
O Whooping Cough
O Tuberculosis
O Other Diseases
_____

Social History (please circle appropriate answer):
Have you ever smoked? Yes No
How many packs per day: _____
For how many years? _____

Do you drink alcohol? Yes No
If so how much per day? _____

Have you ever taken recreational drugs? (ie. Pot, cocaine, crack, etc) Yes No

Are you sexually active? Yes No
Type of Birth Control used? _____

Have you ever been abused? Yes No
If yes, when? _____

For Women Only:
How old were you when your periods started? _____
How many Pregnancies? _____
Miscarriages? ____ Abortions? _____
Date of your last period? _____
Date of last pap smear? _____
Date of last mammogram? _____
Who is your Gynecologist? _____

Family History: Has anyone in your family (blood relatives) had any of these conditions?
O Alcoholism O Bowel Problems O Epilepsy/Seizures O High Blood Pressure O Lung Problems O Psychiatric Problems
O Stroke O Arthritis O Cancer O Heart Problems O Obesity O Kidney Problems
O Diabetes O Skin Problems O Tuberculosis O Bleeding Problems

	Name	Age	Living Medical Problems	Deceased Cause of Death
Mother				
Father				
Siblings				
Spouse				
Children				

HEALTHeLINK

Patient Consent to Participate in HEALTHeLINK Health Information Exchange
Level 1 Multi-Provider/Multi-Payer Consent

Please carefully read the information that follows before making your decision.

You may use this Consent Form to decide whether or not to allow Participating HEALTHeLINK Providers and Payers ("Participants") who are involved in your care to see and obtain access to your electronic health records for treatment and/or care management purposes. This form may be filled out now or at a later date. You can give consent or deny consent to some or all of the Participants. A complete list of Participants can be found at www.wnyhealthelink.com/Home/Patients/Participants. If you have any questions on completing this form go to www.wnyhealthelink.com/Home/Patients/PatientConsent. If you do not have internet access and would like a list of Participants or need help completing this form, please call (716)206-0993 ext 311. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services.**

In this Consent Form, you can choose whether to allow the Participants to obtain access to your medical records through a computer network operated by HEALTHeLINK, which is a part of a statewide healthcare computer network. This helps collect the medical records you have in different places where you get health care, and make them available electronically to the Participants rendering services to you.

SELECT ONLY ONE

☐ **YES** — **I GIVE CONSENT for all Participants who are involved in my care to access ALL of** my electronic health information through HEALTHeLINK. By checking this box you agree that, "Yes, the staff involved in my care including emergency care, quality improvement, care management, and pre-authorization activities at all the Participants may see and get access to all of my medical records through HEALTHeLINK."

☐ **YES EXCEPT** — **I GIVE CONSENT for all Participants who are involved in my care to access ALL** of my electronic health information through HEALTHeLINK except the following Participants:

Participant's Name **Participant's address or phone number**

These Participants cannot access my electronic health information via HEALTHeLINK *EXCEPT in a medical emergency.* If you have chosen to exclude any Participants, you **must** contact HEALTHeLINK at (716)206-0993 ext 311 to verify your form. If you wish to deny consent to additional Participants, please identify them on the Participant Exclusion Form and attach it to this form. You can find the form at www.wnyhealthelink.com/Home/Patients/PatientConsent. If you have attached the Participant Exclusion Form please check here. ☐

☐ **NO EXCEPT** — **I DENY CONSENT for all Participants who are involved in my care to access** my electronic health information through HEALTHeLINK for any purpose, EXCEPT *in a medical emergency.* By checking this box you agree, "No, none of the Participants may be given access to my medical records through HEALTHeLINK unless it is a medical emergency."

☐ **NO NEVER** — **I DENY CONSENT for all Participants who are involved in my care to access** my electronic health information through HEALTHeLINK for any purpose, INCLUDING *in a medical emergency.*

NOTE: Unless you select "NO NEVER" New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through HEALTHeLINK.

PATIENT/LEGAL REPRESENTATIVE

Patient Last Name:

Patient First Name:

Patient Date of Birth: ☐ Male ☐ Female

Patient Address

City **State** **ZIP**

Signature of Patient or Patient's Legal Representative **Date of Signature**

Print Name of Patient's Legal Representative (if applicable)

Relationship of Legal Representative to Patient (if applicable)

☐ parent ☐ healthcare agent/proxy ☐ guardian ☐ other _____

Janet Westenberger, DO

Entity Consent Received By

WITNESS *

* If you are NOT completing this form in a Participant's office, you must have a witness complete the information below.

Print Name of Witness

Signature of Witness

Relationship of Witness to Patient (ex., spouse, son, neighbor, etc.)

Janet Westenberger, D.O.
Family Medicine

3875 North Buffalo Rd.
Orchard Park, NY 14127
(716) 662-6336
FAX (716) 662-6236

HIPAA AUTHORIZATION FORM

I, _____ give permission to the office of Janet Westenberger, DO to:

☐ Use the following protected health information, and/or

☐ Disclose the following protected health information to: _____

_____

_____

(Name(s) of the entity/person to receive your information)

Information to be disclosed (check all that apply):

- ☐ Medical Records
- ☐ Treatment Records
- ☐ Diagnosis Records
- ☐ Other: _____

This protected health information is being used or disclosed for the following purposes: _____

_____

_____

This authorization expires: _____

(Specify (1) date or (2) event that relates to the purpose of this use or disclosure)

If the person or entity receiving this information is not a health care provider of health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits. You may inspect or copy the protected health information to be used or disclosed under this authorization. Finally, you may revoke this authorization in writing at any time by sending a written notification to Janet Westenberger, DO located at 3875 North BuffaloRd., Orchard Park, NY 14127. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

_____ _____

(Signature of Participant or Personal Representative) (Print Name)

_____ _____

(Date) (Description of Personal Representative's Authority)

Patient Payment Responsibility

Janet Westenberger, D.O., PC
3875 North Buffalo Road
Orchard Park, NY 14127
Ph: 716-662-9336
Fx: 716-662-9236

I understand that I am responsible for the full cost of services rendered today if:

1.) I have no insurance
2.) I have HMO insurance but fail to list Dr. Westenberger as my Primary Care Provider (PCP)
3.) I fail to obtain a referral when necessary

I understand that Dr. Westenberger will bill me for any balance for which I am personally responsible.

_____ _____

(Patient/Guardian Signature (Date)

RECORDS RELEASE FORM

To:

_____

_____

_____

I, _____, _____ hereby request that
(Patients name) (Date of Birth)

you release to:

Janet Westenberger, D.O.
3875 North Buffalo Road
Orchard Park, NY 14127
Ph: 716-662-9336
Fx: 716-662-9236

_____ All medical record, including labs, consults, diagnosis, treatment, prognosis, and recommendations as well as other data pertinent to your treatment of me from _____ to _____.

****** Please do not send us the records on a CD as we cannot read them. Paper or Faxed <u>PLEASE</u> ******

_____ Only the information indicated including:

_____

_____

_____

_____ _____
(Patients Name) (Patient or guardian signature)

_____ _____
(Date of Request) (Address)

_____ _____
(Witness) (City, State, Zip)