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 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				

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 disk******
******Mail them on paper ONLY or Fax them to us PLEASE ******

_____ Only the information indicated including:

____

____

____

____
(Patients Name)

____
(Patient or guardian signature)

____
(Date of Request)

____
(Address)

____
(Witness)

____
(City, State, Zip)

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)

Health Care Proxy

(1) I, ____

hereby appoint ____
(name, home address and telephone number)

____

____

*as my health care agent to make any and all health care de*cisions for me, except to the extent that I state otherwise. This proxy shall take effect only when and if I become unable to make my own health care decisions.

(2) Optional: Alternate Agent
If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby

appoint ____
(name, home address and telephone number)

____

____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

(3) Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. *(Optional: If you want this proxy to expire, state the date or conditions here.)* This proxy shall expire *(specify date or conditions)*: ______________________

____

____

(4) Optional: I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. *(If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.)* I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions *(attach additional pages as necessary)*: ______________________

____

____

In order for your agent to make health care decisions for you about artificial nutrition and hydration *(nourishment and water provided by feeding tube and intravenous line)*, your agent must reasonably know your wishes. You can either tell your agent what your wishes are or include them in this section. See instructions for sample language that you could use if you choose to include your wishes on this form, including your wishes about artificial nutrition and hydration.

(5) Your Identification *(please print)*

Your Name ______________________________

Your Signature ______________________________ Date ______________

Your Address ______________________________

(6) Optional: Organ and/or Tissue Donation

I hereby make an anatomical gift, to be effective upon my death, of:
(check any that apply)

☐ Any needed organs and/or tissues

☐ The following organs and/or tissues ______________________________

____

☐ Limitations ______________________________

If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

Your Signature ______________________ Date ______________________

(7) Statement by Witnesses *(Witnesses must be 18 years of age or older and cannot be the health care agent or alternate.)*

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Date ______________________

Name of Witness 1
(print) ______________________

Signature ______________________

Address ______________________

Janet Wes...berger D.O.
3875 North Buffalo Street
Orchard Park, NY 14127
(716) 662-9336

Date ______________________

Name of Witness 2
(print) ______________________

Signature ______________________

Address ______________________

Janet Westenberger D.O.
3875 North Buffalo Street
Orchard Park, NY 14127
(716) 662-9336