Nong Group

429 S. MAIN ST, MILPITAS, CA 95035
Tel: (408) 935-9586 ; Fax: (408) 719-1979

PATIENT REGISTRATION

APELLIDO (Last Name): _____ **NOMBRE DE PILA** (First Name): _____ MI: _____

FECHA DE NACIMIENTO (DOB) _____ GÉNERO (Gender): _____ **ESTADO CIVIL** (Marital Status): _____

DIRECCION DE CASA (Home Address): _____

NUMERO DE TELEFO _____ **Cell Phone #**: _____ Preferred #: _____

CORREO ELECTRONICO (Email Address): _____

FARMACIA (Preferred Pharmacy & Address): _____

CONTACTO DE EMERGENCIA *(EMERGENCY CONTACT)*

APELLIDO (Last Name): _____ **NOMBRE DE PILA** (First Name): _____

NUMERO DE TELEFONO (Phone): _____

MEDICAL HISTORY

Medicamentos que estas tomando (Medications you are taking) _____

_____

Alergias (Allergies:) _____

Estado De Fumar (Smoking Use Status): _____ **Estado De Consumo De Alcohol** (Alcohol Use Status): _____

Nombre y Fecha De Cirugies Anteriores (Name and Date of Previous Surgeries): _____

¿Tiene usted antecedentes o sintomas de alguna de las siguientes condiciones medicas?

(Do you have a history or symptoms of any of the following medical conditions? (please check mark)

☐ **Diabetes** (Diabetes) ☐ **Enfermedad Renal** (Kidney Disease) ☐ **Asma** (Asthma)

☐ **Enfermedad Cardiaca** (Heart Disease ☐ **Enfermedad Pulmonar** (Lung Disease) ☐ **Ulcera estomcal/Reflujo** (Stomach ulcer/Reflux)

☐ **Presion arterial Alta** (High BP) ☐ **Enfermedad De La Tiroides** (Thyroid Disease) ☐ **Transfusion** (Transfusion)

☐ **Colesterol Alto** (High Cholesterol) ☐ **Hepatitis** ☐ **Otros** (Other): _____

☐ **Trastorno Neurologico** (Neurological Disorder)

FAMILY MEDICAL HISTORY

¿Tienes antecedentes familiares de algun enfermedad medica? (Do you have a family history of any medical illness?)

Padre (Father): _____ **Madre** (Mother): _____

Hermana Sister(s): _____ **Hermano** Brother(s): _____

Other: _____

Autorizacion para la divulgacion de informacio medica y la asignacion de beneficios de seguro:

Por la presente autorizo a Nong Group a divulgar, cuando sea necesario informacion medica sobre la atencion y los procedimientos prestados a otros medicos que participan en mi atencion o a programas de seguros para procesar mis reclamaciones de seguro. Tambien autorizo el pago directo a Nong Group de cualquier beneficio de seguro que de otro modo seria pagaderoa mi o en mi nombre por los procedimientos y la atencion medica que me proporciono Nong Group. Entiendo que soy responsable en ultima instancia de cualquier cargo apropiado que no este cubrieto por mis programes de seguro. (Authorization for Release of Medical Information & Assignment of Insurance Benefits: I hereby authorize Nong Group, to release, when necessary, medical information concerning the care and procedure(s) rendered me to other physicians participating in my care, or to insurance programs to process my insurance claims. I also authorize direct payment to Nong Group any insurance benefits otherwise payable to me or on my behalf for the procedure(s) and medical care provided to me by Nong Group. I understand that I am ultimately responsible for any appropriate charges not covered by my insurance programs.)

Patient's Signature: _____ **Fecha** (Date): _____

Del paciente o del Gaurdian si el paciente es menor de edad (Parent's or gaurdian's if patient is under age)

Firma del asegurado si no es el paciente _____

(Signature of the insured if other than patient):

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Pursuant to the requirements found in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the following is offered for your information and consent. Please be aware that it is this office's policy to require your reading and signing this consent prior to the provision of treatment or any other medical services.

I, _____ (your full name), currently residing at _____ (street address) in _____ (city, state & zip),

do hereby consent to the use and disclosure of my individually identifiable health information ("Health Information") by Nong Group for the purpose of providing treatment to me, receiving payment from responsible parties for health care services rendered by Provider, and/or engaging in health care operations, such as office management, credentialing case management and quality management.

I understand that "Notice of Member's Privacy Rights" ("Notice") describes in more detail the types of uses of disclosures of Protected Health Information involved in treatment, payment or healthcare operations, and that I have received a copy of this Notice prior to signing this consent. I understand that if I choose to not sign this consent, this provider may withhold medical services other than emergency services.

I understand that if I sign this consent, I still have the right to request a restriction on Provider's use or disclosure of any and/or all Personal Health Information to any and/or all locations, entities or persons. I further understand that Provider is not olbigated to agree to my request. However, if Provider does agree to my request, the agreement will become binding.

I understand that I have the right to revoke this consent, in writing, at any time, except to the extent that Provider has already relied on this consent, and that any revocation will become effective on the date it has been received by Provider and will apply to uses and disclosures of Health Information after the date of receipt.

Signature: _____ Date: _____