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

PATIENT REGISTRATION

Last Name: ______________________ First Name: ______________________ MI: __________

DOB: ________________ Gender: ________________ Marital Status: ______________________

Home Address: ____

Home Phone #: ________________ Cell Phone #: ________________ Preferred #: ______________

Email Address: ____

Preferred Pharmacy & Address: ____

EMERGENCY CONTACT

Last Name: ___________________ First Name: ___________________ Phone: ________________

MEDICAL HISTORY

Medications you are taking: ____

____

Allergies: ____

Smoking Use Status: ______________________ Alcohol Use Status: __________________________

Name and Date of Previous Surgeries: ____

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

☐ Diabetes	☐ High Cholesterol	☐ Thyroid Disease	☐ Asthma
☐ Heart Disease	☐ Kidney Disease	☐ Neurological Disorder	☐ Transfusion
☐ High Blood Pressure	☐ Lung Disease	☐ Stomach ulcer/Reflux	☐ Other: ______________

FAMILY MEDICAL HISTORY

Do you have a family history of any medical illness?

Father: ________________________________ Mother: ______________________________

Sister(s): ______________________________ Brother(s): ____________________________

Other: ____

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: ____ Date: ______________
(Parent's or gaurdian's if patient is under age)

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, ______________________________________ , currently residing at
(your full name)

__________________________________ in ____________________________ ,
(street address) (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: ____________________