



**Dr. Salma Ahmed Farukhi**  
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Salma Ahmed Farukhi, M.D  
 Family Medicine  
 1211 W LA PALMA AVE. SUITE 503, ANAHEIM CA 92801  
**PATIENT DEMOGRAPHIC**

Referred by: \_\_\_\_\_

Date: \_\_\_\_\_

Patient Full Name \_\_\_\_\_ Preferred Name \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Race: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Preferred Language: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

House Phone: \_\_\_\_\_ Leave a message? Y: \_\_\_ N: \_\_\_ **Emergency Contact Information**  
 Name: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Y: \_\_\_ N: \_\_\_ Relationship: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Y: \_\_\_ N: \_\_\_ Phone: \_\_\_\_\_

Ext: \_\_\_\_\_

Email: \_\_\_\_\_

Preferred Method of Communication: (Please Circle) House Cell Work

Pharmacy Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Cross Streets: \_\_\_\_\_

**Next of Kin**

Full Name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Ext: \_\_\_\_\_ House Cell Work



**Employer Information**

Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Or

**Retired**

**Responsible Party Information**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ SSN: \_\_\_\_\_

Employed by: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

I HEREBY STATE THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST KNOWLEDGE AND AUTHORIZE SALMA AHMED FARUKHI, M.D. TO FURNISH INFORMATION TO INSURANCE COMPAINIES CONCERNING THIS ILLNESS. I HEREBY IRREVOCABLY ASSIGN TO THE DOCTOR ALL PAYMENTS FOR MEDICAL SERVICES RENDERED AND ALL MAJOR MEDICAL BENEFITS DUE FROM MY INSURANCE COMPANY, I UNDERSTAND THAT I AM RESPONSIBLE FOR THESE SERVICES AND THAT THE INSURANCE COMPANY IS RESPONSIBLE TO ME FOR PAYMENT.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Notice of Privacy Practices Acknowledgement



Salma Farukhi, MD
1211 W. La Palma Ave Suite #503
Anaheim, CA 92801
P: (714) 533-1703

I understand that under the Health Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow up among the multiple health care providers who may be involved in the treatment directly or indirectly.
• Obtain payment from third party payers.
• Conduct normal health care operations such as quality assessments and physician certification.

I have received, read, and understand the "Notice of Privacy Practices" containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its "Notice of Privacy Practices" from time to time and that I may contact this organization at any time at this address above to obtain a current copy of the "Notice of Privacy Practices."

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do not agree then you are bound to abide by such restrictions.

Patient Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Or

Patient Representative Signature: \_\_\_\_\_

Date: \_\_\_\_\_

OFFICE USE ONLY

I attempted to obtain the signature of the patient or patient's representative acknowledging the receipt of the "Notice of Privacy of Practices" for My MD Multispecialty Care / Salma A. Farukhi, but was unable to do so as documented below.

Table with 3 columns: Date: \_\_\_\_\_, Initials: \_\_\_\_\_, Reason: \_\_\_\_\_



**HEALTH QUESTIONNAIRE**

Name \_\_\_\_\_ Age: \_\_\_\_\_ Gender:  Male  Female  
 Address \_\_\_\_\_  
 Phone ( ) \_\_\_\_\_ Referred by \_\_\_\_\_

HISTORY OF PAST ILLNESSES:

Have you had any of the following:

• **Childhood**

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever of heart disease	<input type="checkbox"/>	<input type="checkbox"/>
Chickenpox	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Venereal diseases	<input type="checkbox"/>	<input type="checkbox"/>
Measles	<input type="checkbox"/>	<input type="checkbox"/>	Congenital abnormalities	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Other serious diseases	<input type="checkbox"/>	<input type="checkbox"/>
Strokes	<input type="checkbox"/>	<input type="checkbox"/>	name of disease _____		

• **Adult**

- Have you had any serious illnesses?  Yes  No If so, please list the name of the disease and the time period when you had it on this line \_\_\_\_\_
- Have you ever been hospitalized or been under medical care for very long?  Yes  No If yes, for what and when? \_\_\_\_\_

• **Operations**

- Have you had any surgery?  Yes  No If so, please list when you had surgery and for what purpose on the following lines.  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

• **Injuries**

- Have you broken any bones?  Yes  No If so, please list which bones and when you broke them on the following line \_\_\_\_\_
- Have you had any head concussions or injuries?  Yes  No
- Have you ever been knocked unconscious?  Yes  No

FAMILY HISTORY:

RELATIVE	If Living		If Deceased	
	Age	Health	Age at death	Cause
Father				
Mother				
Brother/Sister				
Husband/Wife				
Son/Daughter				

Has any blood relative ever had any of the following?

	<u>Yes</u>	<u>No</u>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>
Suicide	<input type="checkbox"/>	<input type="checkbox"/>
Insanity	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding tendency	<input type="checkbox"/>	<input type="checkbox"/>
Gout or other arthritis	<input type="checkbox"/>	<input type="checkbox"/>

**Please Turn Over**