



Salma Ahmed Farukhi, M.D  
 Family Medicine  
 2680 N. Santiago Blvd Suite 100, Orange CA 92867  
**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: \_\_\_\_\_

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

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

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**

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**Responsible Party Information**

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

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

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

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: \_\_\_\_\_





**Salma Ahmed Farukhi, MD**  
**Family Medicine**

2680 N. Santiago Blvd Suite 100, Orange CA 92867

P: (714) 602-7492

F: (714) 509-1377

## RELEASE OF MEDICAL RECORDS

TO: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I, the undersigned, hereby authorize and request the above to release the following information:

- All Medical records
- Specifically \_\_\_\_\_  
During periods between \_\_\_\_\_ and \_\_\_\_\_

To:  
  
Salma Ahmed Farukhi, M.D  
2680 N. Santiago Blvd Suite 100, Orange CA 92867  
P: (714) 602-7492  
F: (714) 509-1377

For the purpose of diagnoses and treatment. The requested information will only be released. An additional written consent will and must be obtained for any new or different use of the information that is authorized herein or for the transfer of this information to another person or entity. Please fax or mail a copy of this form to the address above.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Witness: \_\_\_\_\_ Date: \_\_\_\_\_

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

**Notice of Privacy Practices Acknowledgement**



Salma A. Farukhi, MD

2680 N. Santiago Blvd Suite 100, Orange CA 92867

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:** \_\_\_\_\_

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**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.

Date: _____	Initials: _____	Reason:
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