

BROOKHURST FOOT & ANKLE CLNIC, INC.

Chuc.B. Dang; D.P.M., FACFAS 18821 Delaware St.

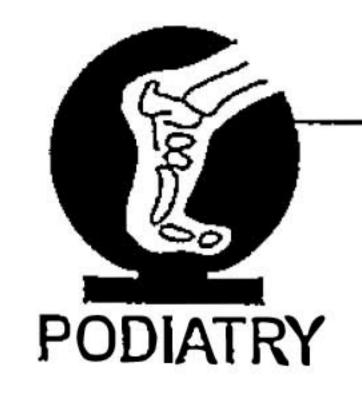
Hunt.ingt.on Beach: CA 92648

Phone: (714)775-5373 Fax: (657) 329-0016

E-Mail: brookhurstfootclinic@yaloo.:

Nambra (Tân I art Eira)	Date of Birth: Sex: Male Female
Nombre/Tên Last First Middle	Cumpleaños/Ngày Sanh Masculino/Nam Hembr
Home Address	
Dirección de su casa/Ði a Chi Nhà	
Home Phone #	Cell Phone #:
Teléfono de ca ø/Điện Thoại Nhà	Teléfono celular/Điện Thoại Di Động
Employer:	City, State
Empleador/Hāng Sử	Cłudad/Tinh, Estado/TiEu Bang
Office Phone #:	E-Mail Address:
Teléfono de la oficina/Điện Thoại Văn Phòng	Dirección de correo electrónico/Ðja Chi Email
Insurance Name:	_ Group ID #:
Seguro/Bảo Hiểm	Número de identificación de grupo/Nhóm Số
Member ID #	Social Security #
Número de ID/Số Thành Viên ID	Número de seguro social/Số An Sinh Xā Hội
Relative's Name:	Relationship:
Pariente Nombre/ Tên người thân .	Relación/Mối Quan Hệ
Emergency Contact	Relationship:
Contacto de Emergencia/Người Liên Lạc Khấn Cấp	Relación/Μδί Quan Ηξ
Home Phone#::	Cell Phone #
Teléfono celular #/ Điện thoại di động #	Teléjono#/ điện thoợi #
Referred By: Phari	macy Name/Location:
Referido por/giới thiệu bởi	acia Nombre/Ublcación /Dược phẩm Tên/nơi
light of circumstance is possible and practical. The PATIEN obtaining such medications as are prescribed by following to such treatment regimen or course of action as may be set provided by prior special arrangements. IT IS AGREED that is in no way possible to warrant the outcome of such podiate PATIENT or dependent (whether or not a minor) or the heir may be and the ATTENDING PODIATRIST (including his same shall be submitted to liticotion. All notices or other particular for the fees and charges of the ATTENDING PODIA	T will cooperate fully with the ATTENDING PODIATRIA he instructions of the ATTENDING PODIATRIST by add forth and by paying all fees and charges in full as billed at because of differences in human constitution and respond care and service. In the event of any controversy between seat-law or personal representative of a PATIENT as the agents and employees) involving a claim in tort or contrapers required to be served shall be served by United State ATRIST may be sued on in any proper court. By our sign
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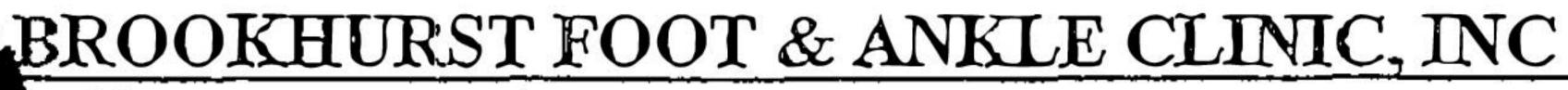
18821 Delaware St..
Huntington Beach, CA 92648

Tel: (714) 775-5373 Fax: (657) 329-0016

PAST OR PRESENT HISTORY (NOT LIMITED TO THE FEET) HISTORIA MEDICA

(Please allow us to aid you if need be)

Name of family Doctor: Normbre de su Doctor:	· · · · · · · · · · · · · · · · · · ·	
Last time seen: Es usted alergico:		
Any medical condition treated: Padece de alguna enfermedal:		
Past injuries and surgeries:		
List your allergy: Es usted alergico:		
Ever have injection of Novacaine? A sido inyectado con Novacaine?		
What medication are you taking? Alguna medication que est tomando		
Is there any family history of Asthma?	~ ~	
Present chief complaint: Sintomas de su problema:		
Location: Lugar del dolor:		
When did it start and how did it start?		
Has anything been done to relieve it?		
Is it better or worse same? A notado algun cambio		
List past foot care: Ha tenido problemas anteriormente con los		
	Patient's signature	



Chuc B. Dang, D.P.M

PODIATRY

18821 Delaware St.
Huntington Beach, CA 92648
Tel: (714) 775-5373
Fax: (657) 329-0016

Provider Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

Uses and disclosures of health information

We use health information about you for treatment (diagnostic treating, prescription, referral, etc.) to obtain payment (submit claims and/or encounters to billing services and/or clearinghouses, and/or collection agencies, etc.) for administrative purposes (reporting, utilization management, quality improvement and surveys, etc.) and to evaluate the quality of care you receive. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may us or disclose identifiable health information about you without your authorization for several other reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization stop any future uses and disclosures.

We may apply a change to our policies at any time. Before we make a significant change in our policies, we will change out notice; and post the new notice in [the waiting area and din each examination room.] You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Individual rights

You have the right to look at, get a copy of our receive electronically protected health information about you that we use to make decisions about you. If you request copies, we will charge you \$15-25 for each medical record. You also have the right to receive a list of instances where we have disclosed protected health information about you for reasons other than treatment, payment or related administrative purposes. If you believe that information in your record is incorrect or if important information is missing, you have the right to request in writing that we amend the existing information.

You may request in writing that we restrict and/or not use or disclose your information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to agree to it.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

Our legal duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

I acknowledge that I have received a copy of the PROVIDER NOTICE OF PRIVACY PRACTICES as required by the Heath Information Portability and Accountability Act. I understand that upon completion of reading the notice, any questions I may have may be addressed to the PROVIDER PRIVACY OFFICER.

Signature	Date			
NOTICE OF PRIVACY PRACTICES Refusal to Sign-Patient has the right to refuse to sign and has decided not to sign				
Signature of Privacy Officer	Date			