Health First Medical Center
314 Agler Rd
Gahanna, OH 43230
Tel: 614-944-9029
Fax: 614-944-9034
www.healthfirstmc.com

Patient Registration

Patient Name:____
Last First

Date of Birth:_______________ Social Security Number: ___________________________

Circle Male or Female Home Address:____
Street Number Street Name

____
City State Zip Code

Cell Phone:______________ Hm Ph:___________ Email Address:_____________________

Pharmacy Name:__________________ Pharmacy Phone Number:_____________________

Emergency Contact Information

Person to call in case of emergency:___________________ Relationship:___________
Phone Number:____________________

Signature:_______________________ Today's Date:______________

Health First Medical Center
314 Agler Rd
Gahanna, OH 43230
T: 614-944-9029 F: 614-944-9034
www.healthfirstmc.com

Patient Name: ____ **Date of Birth:** ______________

Date of surgery: _____________________ **Surgeon's Name:** ____________________________________

Name of Surgery Center: ______________________________**Type of surgery**:_____________________

Allergies: ☐ Penicillin ☐ Sulfa ☐ Latex ☐ Other: ____

Past Medical History: ☐ High blood pressure ☐ Diabetes ☐ Coronary artery disease/heart stents/heart attack ☐ heart murmur ☐ mitral valve prolapse ☐ atrial fibrillation ☐ seizures ☐ difficulty swallowing

☐blood clots ☐ rheumatoid arthritis ☐ stroke ☐ heart failure ☐ pacemaker/defibrillator ☐ cancer

☐ high cholesterol ☐ blood thinner ☐ sleep apnea: with or without c-pap or bipap (circle one)

☐ lung disease ☐ liver disease ☐ kidney disease ☐ vocal cord dysfunction ☐Other/explanation of above:

____

____

Past Surgical History: ☐ tonsillectomy ☐ appendectomy ☐ gallbladder ☐ hysterectomy ☐ hip replacement left/right (circle one) ☐ knee replacement left/right (circle one) ☐ carpal tunnel left/right

☐ prostate surgery ☐ coronary bypass ☐ pacemaker or defibrillator placement ☐ throat surgery

Implanted devices: ☐heart stents ☐brain stimulator ☐bladder stimulator ☐insulin pump

☐ Other:

____

____

Family History: ☐ Premature coronary artery disease ☐ bleeding disorders ☐ complications with anesthesia

Smoking status: ☐ Never smoker ☐ Former smoker ☐ Current everyday/amount:________________

Alcohol use: ☐ No ☐ Yes/amount: ____

Name and phone number of cardiologist: ____

Medications:

Consent to Obtain Medical Records

I do hereby consent and authorize you to release copies of my medical records, including current and previous medical records from other practices and practitioners, hospitals, and/or clinics, which are a part of my medical records.

Patient's Signature: ______________________________________ Date: ________________
Parent/Guardian (If a minor) ______________________________ Date: ________________
Witness:____

************** **To Be Filled out by the Office Staff – Patient does not need to fill out below*******

Patient's Name ____
Patient's Address ____
Patient's Date of Birth ____
Patient's Social Security Number ____
Please release my medical records from (Name, Address, Phone Number, Fax Number):
____
____
____
____

Please Send my medical records to:

Health First Medical Center
314 Agler Rd
Gahanna, OH 43230
Tel: 614-944-9029
Fax: 614-944-9034
www.healthfirstmc.com

HIPAA Compliance Patient Consent Form

Our notice of privacy practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operation
- The practice reserves the right to change the privacy policy as allowed by law
- The patient has the right to restrict the use of the information, but the practice does not have to agree to those restrictions
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease
- The practice may condition receipt of treatment upon execution of this consent

May we leave a message on your answering machine at home or on your cell? YES NO
May we discuss your medical condition with any member of your family? YES NO
If YES, please name the members allowed and Relationship:_____________________________________
____

This consent was signed by: _______________________________ (PRINT NAME PLEASE)
Signature:_________________________________ Date:________________________________

NOTICE OF PRIVACY PRACTICES (Medical)

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

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

**Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

**Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

**Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal assessment review. We may also create and distribute de-identified health information by removing all references to individually identifiable information. 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. Any other uses and disclosures will be made only with your written authorization.

You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we already have taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Offer.

**The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends or any person identifiable by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

**The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alterative locations.

**The right to inspect and copy your protected health information.

**The right to amend your protected health information.

**The right to receive an accounting of disclosures of protected health information.

**The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of April 1, 2003 and we are required to abide by the terms of this Notice of Privacy Practice currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice. We will not retaliate against you for filing a complaint. For more information about HIPAA or to file a complaint:

The Health First Medical Center Privacy Officer 314 Agler Rd. Gahanna, OH. 43230 (614) 944-9029

The US Dept of Health and Human Services Office of Civil Rights 200 Independence Ave. SW Washington, DC 20201 202-619-0257 or 1-800-696-6775