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:**______________________

Primary Care Doctor:________________________ **Doctor's Phone Number:**______________

Pharmacy Name:__________________ **Pharmacy Phone Number:**_____________________

Emergency Contact Information

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

Signature:_______________________ **Today's Date:**______________

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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: **X** ________________________________ Date: **X** ______________
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:

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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: X ______________________________ (PRINT NAME PLEASE)

Signature: X ________________________________ Date: X _______________________________