



Health First
— Medical Center —

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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Health First

Patient Name: _____ Date of Birth: _____

Date of surgery: _____ Surgeon's Name: _____

Are You Covid Vaccinated: Yes No

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

MEDICATIONS: PLEASE LIST MEDICATIONS & DOSAGE. WRITE NONE IF NOT TAKING ANY. IF YOU HAVE A LIST WE CAN MAKE A COPY UP FRONT. WE CANNOT SEE YOU IF YOU DON'T FILL OUT THIS INFORMATION.

Smoking status: Never smoker Former smoker Current everyday/amount: _____

Alcohol use: No Yes/amount: _____

Name and phone number of cardiologist: _____



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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** _____