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: _____ DOB:_____

Date of Surgery:_____ Surgeon's Name:_____

Name of Surgery Center:_____ Type of surgery:_____

Allergies: __Penicillin __Sulfa __Latex Other:_____

Past Medical History:

___High Blood Pressure ___High Cholesterol ___Coronary Artery Disease/heart attack ___Heart Murmur

___Atrial Fibrillation ___ Heart Failure ___Pacemaker/Defibrillator ___Diabetes ___Prediabetes

___COPD ___Asthma __Sleep apnea with without CPAP-BIPap ___Cancer ___GERD ___Arthritis

___Seizures ___Stroke ___Anemia ___Blood Clots ___Blood Thinners ___Difficulty Swallowing

___Fatty Liver ___Cirrhosis of Liver ___Hepatitis ___Kidney Disease ___Thyroid disease

Other:_____

Past Surgeries: ___Tonsils/Adenoids ___Appendix ___Gallbladder ___Hysterectomy

___Hip Replacement: Left Right ___Knee Replacement: Left Right

___Shoulder Replacement: Left Right ___Carpal Tunnel: Left Right ___Prostate Surgery

___Heart Stents ___Heart By-Pass ___Bladder stimulator ___Brain Stimulator ___Insulin Pump

___Spinal Cord Stimulator

Other Surgeries:_____

_____

Family History: __Premature coronary artery disease __bleeding disorder __complications to anesthesia

Smoking Status: ___Yes ___Never ___Former smoker ___Vape ___Chew/Smokeless Tobacco

Alcohol Use:___Yes: How much_____ ___No

Name and Phone Number of Cardiologist if you see one:_____

MEDICATIONS

PLEASE LIST ALL MEDICATIONS. If you have a list we can make a copy of that instead

We cannot clear you for surgery if we do not know what medications you are taking

In the last 3 weeks have you taken any steroids [prednisone] by mouth or had a steroid injection? Yes No

Name	Dosage	How Many Times per Day

Health First
Medical Center

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**_____