Health 1st Family Medicine
Nghiep Nguyen, MD | Nhu Luong, PA-C
2212 S Post, Suite A, Midwest City, OK 73130

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____
Date of Birth: _____/_____/_____ Age: _____ Male / Female SSN: _____
Address: _____
City: _____ State: _____ Zip: _____
Home: (_____)_____-_____ Cell: (_____)_____-_____
Employer: _____

IN CASE OF AN EMERGENCY, I GIVE PERMISSION TO NOTIFY:

Name: _____ Phone: (_____)_____-_____

Relationship: _____

(*If < 18 yo*) PERSON RESPONSIBLE FOR BILL

Last Name: _____ First Name: _____ M: _____
Date of Birth: _____/_____/_____ Age: _____ Male / Female SSN: _____
Address :_____
City: _____ State: _____ Zip: _____
Home: (_____)_____-_____ Cell: (_____)_____-_____

X_____ Date : _____/_____/_____

Signature of Patient/Legal Guardian

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ACKNOWLEDGEMENT OF RECEIPT
HIPAA NOTICE OF PRIVACY PRACTICES AND CLINIC POLICIES

A complete copy of the Facility's HIPAA Notice of Privacy Practices and Clinic Policies are posted in the facility and individual copies are available upon request.

By signing below, you acknowledge that you have **received/read** the HIPAA Notice of Privacy Practices **and** Clinic Policies.

_____
Please print name

_____
Signature

_____
Date

*IF PATIENT IS A MINOR **(<18 yo)** OR INCOMPETENT: I hereby acknowledge that I have received/read a copy of the HIPAA Notice of Privacy Practices and Clinic Policies on behalf of the patient.*

_____
Name: Parent/Legal Guardian

_____
Signature: Parent/Legal Guardian

_____
Date

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Patient Name:_____ Age_____ Date_____
What is the main reason for your appointment today? _____
How long have you had this problem? _____
Pharmacy Name & Location: _____

(Please circle all that apply)

Personal Medical Problem:

- High blood pressure
- Diabetes
- High cholesterol
- Depression/Anxiety
- Headache / Migraine / Seizure
- Asthma / COPD
- Heart stent / Heart bypass
- Arthritis
- Heartburn
- Fracture of _____
- Kidney disease
- Thyroid
- Stroke
- Cancer of _____
- Other _____

Surgery:

- Appendix
- Gallbladder
- C-section
- Hysterectomy
- Tonsils
- Cataract
- Other _____

Circle please:
Self Pay
Private Insurance
Soonercare
Medicare

Family History:

- High blood pressure
- Diabetes
- High cholesterol
- Depression/Anxiety
- Thyroid
- Heart Disease
- Cancer of_____
- Other _____

Social history:
Smoking: **Yes / No** Pack _____ Years _____ Alcohol abuse: **Yes / No**
Substance Abuse: **Yes / No** Type: _____ Job/Grade/School: _____
Feeling down, lack of interest or hopeless? **Yes / No**
Living will, Advance Directives, Power of Attorney? **Yes / No**
Married Divorced Widowed Single

Allergies: (*Upset stomach is NOT an allergy*)
_____ Reaction:_____

Current medications:

1._____ _____mg/g How often?_____
2._____ _____mg/g How often?_____
3._____ _____mg/g How often?_____
4._____ _____mg/g How often?_____
5._____ _____mg/g How often?_____

_____lb _____in _____T _____BP _____HR _____%