HEALTH First
MEDICAL CENTER

Syed F. Hussain M.D.
Patient Update Forms

Patient Last Name _____First Name_____

DOB _____/_____/_____ Social Security #_____/____/_____

Address _____

City _____State _____ Zip _____

Employer _____Occupation_____

Email Address _____

Home Phone _____

Cell Phone _____

Work Phone _____

Preferred Method of Contact (Circle One) Email 1, Home Phone, Cell Phone, Work Phone

Would you like to receive reminder text messages? (Circle One) Yes No

Birth Sex: Male ____ Female ____ Gender Identity: Male____ Female____

Sexual Orientation: (Circle One) Straight, Bisexual, Lesbian or Gay, Choose not to disclose

Marital Status: (Circle One) Single, Married, Divorced, Domestic Partner, Widow(er)

Race: (Circle One) White, Black, Hispanic, Native American/Alaskan Native, Bi-Racial

Other _____

Ethnicity: Circle One: Hispanic/Latino, Not Hispanic/Latino

Dominant Hand: (Circle One) Left, Right, Ambidextrous

Language Preference_____

Do you require a translator? YES or NO

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Primary Insured Information

Insurance Company_____

Policy ID#_____ **Group#**_____

Guarantor Name_____**Relationship**_____

DOB____/____/_____ **SS#**_____/_____/_____

Address_____

City_____ **State** _____**Zip**_____

Home Phone_____ **Work Phone**_____

Employer_____ **Occupation**_____

Effective Date____/_____/_____

Secondary Insured Information

Insurance Company_____

Policy ID#_____ **Group#**_____

Guarantor Name_____**Relationship**_____

DOB____/____/_____ **SS#**_____/_____/_____

Address_____

City_____ **State** _____**Zip**_____

Home Phone_____ **Work Phone**_____

Employer_____ **Occupation**_____

Effective Date____/_____/_____

I hereby authorize release of information necessary to file a claim with my insurance company. I assign benefits to be paid to Health First Medical Center and I understand that I am financially responsible for charges for medical services rendered to the above named patient regardless of insurance coverage, including amount not limited to any and all immunizations. In the event of collection proceedings due to lack of payment on my part, I agree to pay any and all collection fees that may be added to my account in order to recover monies due.

Patient or Guarantor Signature_____ **Date**_____/_____/_____

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Current Medications:

DRUG NAME	STRENGTH	DOSAGE

***let us know if you need an additional space or attach a copy of your medication list**

Social History

Tobacco use: Yes____ No_____ Quit?_____ When?_____
Current illicit drug use: Yes_____ No_____ Type?_____
Past illicit drug use: Yes_____ No_____ Type?_____
Alcohol use: Yes_____ No_____ How much? _____
Do you exercise regularly? Yes_____ No_____ How Often?_____
Do you have a living will or advanced directive? Yes _____ No_____

Patient Signature:_____ **Date:**_____

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Local Pharmacy Information:

Patient Name: _____

Pharmacy Name:_____

Address or Cross Streets:_____

Pharmacy Phone Number:_____

Mail Order Pharmacy

Pharmacy name:_____

Do you prefer 30 day or 90 day prescriptions? Circle one

I authorize my pharmacy to provide my medication list and history to Health First Medical Center.

Patient Signature:_____
Date:____/_____/_____

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HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

Patient Name:_____

Date of Birth _____/_____/_____ **SS#**_____-_____-_____

I authorize _____**(previous healthcare provider or specialist) to use and disclose the protected health information described below to:**

Syed F. Hussain MD
1641 E Flamingo Road #10
Las Vegas, NV 89119
Fax: 702-369-8057

Effective Period - This authorization for release of information covers the period of healthcare from: □ _____ **to** _____ **OR** □ **all past, present, and future periods.**

Extent of Authorization

□ **I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).**

OR

□ **I authorize the release of my complete health record with the exception of the following information:**

□ **Mental health records**
□ **Communicable diseases (including HIV and AIDS)**
□ **Alcohol/drug abuse treatment**
□ **Other (please specify):** _____

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

This authorization shall be in force and effect until _____/_____/_____ **(date or event), at which time this authorization expires.**

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the an insurer has a legal right to contest a claim. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____

Signature of patient or personal representative

_____

Printed name of patient or personal representative and his or her relationship to patient

_____/_____/_____

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2026 PATIENT CODE OF CONDUCT

The prevalence of workplace violence in health care remains higher than most professions. According to the Occupational Safety and Health Administration (OSHA), approximately 75 percent of nearly 25,000 workplace assaults reported annually in health care and social service settings.

In an effort to provide a safe and healthy environment for staff, visitors, patients and their families, Fa Health First Medical Center expects visitors, patients and accompanying family members to refrain from unacceptable behaviors that are disruptive or pose a threat to the rights or safety of other patients and staff.

The following behaviors are prohibited:

- Possession of firearms or any weapon
- Physical assault, arson or inflicting bodily harm
- Throwing objects, stealing supplies, decorations, other office property, etc.
- Intoxication due to alcohol or illicit drugs.
- Making verbal threats to harm another individual or destroy property
- Intentionally damaging equipment or property
- Making menacing gestures, inappropriate touching of the staff, patients, or visitors
- Attempting to intimidate or harass other individuals
- Making harassing, offensive or intimidating statements (aggressive speech or profanity), or threats of violence through phone calls, letters, voicemail, email, or other forms of written, verbal or electronic communication
- Racial or cultural slurs or other derogatory remarks associated with, but not limited to, race, language or sexuality.

If you are subjected to any of these behaviors or witness inappropriate behavior, please report to any staff member. **By signing below you acknowledge these policies and agree to abide by them. Violators are subject to removal from the facility and/or discharge from the practice.**

*Adults are expected to supervise children in their care.

Name_____ Date_____

Signature_____

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Emergency Contact Information

* In the event of an emergency or if we are unable to contact you, we will contact the below listed individual(s) to attempt to make contact with you.

Patient Name_____

DOB _____/_____/_____

Patient's Relationship to Contact _____

First Name _____ **Last Name** _____

Cell Phone_____

Work Phone_____

Home Phone _____

If you have multiple contacts you wish to add, please list them below or request an additional form.

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Patient Record of Disclosure

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner: (Check all that Apply)

Home Telephone

___ Ok to leave message with detailed information

___Leave message with call back number only

Written Communication

___ Ok to mail to home address

___ Ok to fax to this #_____

Cell Phone

___ Ok to leave message with detailed information

___Leave message with call back number only

Work Telephone

___ Ok to leave message with detailed information

___Leave message with call back number only

Individuals whom you allow health information released to:

Name_____ **Relationship** _____

Name_____ **Relationship** _____

Name_____ **Relationship** _____

_____ _____/_____/_____

Patient name (Printed) Date of Birth

_____ _____

Signature Date