



PATIENT DEMOGRAPHICS

CHART #: \_\_\_\_\_
Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_
Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Race: \_\_\_\_\_
Social Security #: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Other/Cell: \_\_\_\_\_
Voice mail messages may be left on the following telephone number(s): \_\_\_\_\_
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
Email Address: \_\_\_\_\_
Patient's Employer Name: \_\_\_\_\_ Employer's Phone: \_\_\_\_\_
Employer Address: \_\_\_\_\_
Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_
Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_
Preferred Pharmacy: \_\_\_\_\_ Pharmacy Location: \_\_\_\_\_
How did you hear about our Practice? \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_
Social Security #: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Other/Cell: \_\_\_\_\_

#1 Insurance Company: \_\_\_\_\_ (BCBS, Cigna, Medicare, etc.)
Primary Card Holder's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_
Patient's relationship to the insurance policy holder: \_\_\_\_\_ Member ID#: \_\_\_\_\_
Policy Holder's SS#: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Other/Cell: \_\_\_\_\_
Address: \_\_\_\_\_

#2 Insurance Company: \_\_\_\_\_ (BCBS, Cigna, Medicare, etc.)
Primary Card Holder's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_
Patient's relationship to the insurance policy holder: \_\_\_\_\_ Member ID#: \_\_\_\_\_
Policy Holder's SS#: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Other/Cell: \_\_\_\_\_
Address: \_\_\_\_\_

- I authorize the release of any medical information necessary to process health insurance claims. I request payment of benefits be made directly to MICHAEL CAHN, MD. Any unexpected balance left after insurance payment has been received will be due in full within 30 days of notification from this office. \_\_\_\_\_ (initials)
I give my consent to MICHAEL CAHN, MD and their physicians and health care professionals, to provide treatment, examinations and/or evaluations, etc., as deemed necessary to the above named patient. \_\_\_\_\_ (initials)
I authorize release of all medical records from any medical facility or physician to MICHAEL CAHN, MD. \_\_\_\_\_ (initials)

Signature \_\_\_\_\_ Date: \_\_\_\_\_
Witness \_\_\_\_\_ Date: \_\_\_\_\_



NOTICE OF PRIVACY PRACTICE

I, \_\_\_\_\_, DOB: \_\_\_\_\_, AUTHORIZE \_\_\_\_\_ (PHYSICIAN NAME)

TO DISCLOSE THE FOLLOWING INFORMATION FROM MY RECORDS FOR THE PURPOSE OF TREATMENT, HEALTH CARE OPERATIONS, BILLING AND PAYMENT, OR OTHER: \_\_\_\_\_

INFORMATION TO BE DISCLOSED:

- Health record (includes: treatment, health care operations, billing and payment, etc.)
History & physical examinations
Consultation reports
Progress notes
Operative notes
Ultrasound reports
X-ray reports
Laboratory tests
Photographs, video tapes, digital or other images
Discharge summaries
Billing information
Other: \_\_\_\_\_
ALL OF THE ABOVE

INFORMATION IS TO BE DISCLOSED TO:

- Family, Guardian or Representatives: \_\_\_\_\_
Physicians
Clinics, hospitals or surgical centers
Insurance companies
Other: \_\_\_\_\_
ALL OF THE ABOVE

The facility, its employees, officers and physicians are hereby released from any legal responsibility for disclosure of this information to the extent indicated and authorization herein.

I have read the contents of the NOTICE OF PRIVACY PRACTICES. I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment and health care operations.

SIGN: \_\_\_\_\_ PATIENT/LEGAL GUARDIAN
\_\_\_\_\_ RELATIONSHIP TO PATIENT
\_\_\_\_\_ WITNESS
\_\_\_\_\_ DATE

NOTICE TO PATIENT: By signing this form, you grant us consent to use and disclose your protected health care information for the purpose of treatment, various activities associated with payment and healthcare operations. Our NOTICE OF PRIVACY PRACTICES provides more detail on our treatment, payment activities and health care operations. If there is not a copy of the NOTICE accompanying this consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care. This authorization will expire only when you notify us in writing or in person.

REFUSAL TO CONSENT: NOT TO AUTHORIZE/CONSENT TO RELEASE RECORDS TO ANYONE.

By signing below, you agree that it has been explained and you understand that no records will be sent to anyone without you returning to the office to complete a new release form.

I, \_\_\_\_\_ (Chart #: \_\_\_\_\_), DO NOT WANT MY RECORDS SENT TO ANYONE.

SIGN: \_\_\_\_\_ PATIENT
\_\_\_\_\_ DATE



**ACKNOWLEDGEMENT OF CONSENT**

NOTICE TO PATIENT: \_\_\_\_\_

We are required to provide you with a copy of our **NOTICE OF PRIVACY PRACTICE**, which states how we may use and/or disclose your health information. Please sign this form to acknowledge your consent of our NOTICE on the previous page. You may refuse to sign this acknowledgment, if you wish.

I acknowledge my consent to this office's **NOTICE OF PRIVACY PRACTICES**.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**FOR OFFICE USE ONLY**

We have made every effort to obtain written acknowledgement of receipt of our **NOTICE OF PRIVACY** from this patient, but it could not be obtained because:

- 1. The patient refused to sign.
- 2. Due to an emergency situation, it was not possible to obtain an acknowledgement.
- 3. We weren't able to communicate with the patient.
- 4. Other (please provide specific details): \_\_\_\_\_

\_\_\_\_\_



VEIN CONSULT QUESTIONNAIRE

Name: \_\_\_\_\_ Date: \_\_\_\_\_

DOB: \_\_\_\_\_ Occupation: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Family Doctor: \_\_\_\_\_

Are you currently being treated by any other physicians?  No  Yes

If yes, physician's name: \_\_\_\_\_ Phone: \_\_\_\_\_

List current medications and dosages:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List ALL allergies: \_\_\_\_\_

Are you pregnant or planning a pregnancy?  No  Yes How many pregnancies have you had? \_\_\_\_\_

Have you had any miscarriages?  No  Yes If yes, how many? \_\_\_\_\_

Does your family have a history of miscarriages?  No  Yes

Do you take birth control pills or hormones?  No  Yes

List previous surgeries and dates below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever had general anesthesia?  No  Yes If yes, any complications? \_\_\_\_\_

Have you ever had local anesthesia?  No  Yes If yes, any complications? \_\_\_\_\_

Do you drink alcoholic beverages?  No  Yes If yes, how many per week? \_\_\_\_\_

Do you now, or have you ever, used tobacco?  No  Yes Packs/Week: \_\_\_\_\_ Quit Date: \_\_\_\_\_

Do you exercise regularly?  No  Yes Number of times per week: \_\_\_\_\_

## Vein History

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How long have you been suffering from varicose vein disease? \_\_\_\_\_

Where are the veins for which you are seeking evaluation?

Right Leg     Left Leg     Both Legs     Face

Have you ever had your veins evaluated before?     No     Yes

If yes, when? \_\_\_\_\_    Where? \_\_\_\_\_

Have you ever worn prescription grade compression stockings?     No     Yes

If yes, when? \_\_\_\_\_    For how long? \_\_\_\_\_

Do you have a family history of vein problems?     No     Yes

If yes, which family member(s)? \_\_\_\_\_

Have you ever been on a blood thinner?     No     Yes

If yes, type, when and why? \_\_\_\_\_

Please check each symptom that applies to you:

- |   |                                   |                                    |   |
|---|-----------------------------------|------------------------------------|---|
| <input type="checkbox"/> Leg Pain       | <input type="checkbox"/> Burning  | <input type="checkbox"/> Itching   | <input type="checkbox"/> Restless Leg     |
| <input type="checkbox"/> Aching Legs    | <input type="checkbox"/> Cramps   | <input type="checkbox"/> Tiredness | <input type="checkbox"/> Discoloration    |
| <input type="checkbox"/> Throbbing Pain | <input type="checkbox"/> Swelling | <input type="checkbox"/> Heaviness | <input type="checkbox"/> Leg Sores/Ulcers |

Which leg is worse?     Right     Leg

How far can you walk before feeling pain in your legs? \_\_\_\_\_

How do you relieve the pain in your legs? \_\_\_\_\_

Have you ever had: (check all that apply)

Phlebitis (clot in surface veins in legs)    When? \_\_\_\_\_

More than one episode of phlebitis    When and where? \_\_\_\_\_

Deep Vein Thrombosis    When? \_\_\_\_\_

*(continued from previous page)*

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- Pulmonary Embolus (blood clots in lungs)    When? \_\_\_\_\_
- Bleeding from Veins    When? \_\_\_\_\_
- Sclerotherapy    When? \_\_\_\_\_
- Venogram (Vein X-Ray)    When? \_\_\_\_\_
- Vein Surgery    When? \_\_\_\_\_
- Hemorrhoids    When? \_\_\_\_\_
- IV Drug Use    When? \_\_\_\_\_
- AIDS/HIV    When? \_\_\_\_\_
- Hepatitis    When? \_\_\_\_\_
- Trauma / Injury to Leg(s)    When? \_\_\_\_\_
- Clotting Disorder    When? \_\_\_\_\_

Any other comments you would like to add? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Mark any of the following conditions you or a family member has EVER experienced (please check all that apply).

| CONDITION  | SELF | FAMILY | PLEASE EXPLAIN |
|--|------|--------|----------------|
| Heart Disease  |      |        |                |
| Irregular Heartbeat/Atrial Fibrillation                        |      |        | Specify:       |
| Angina (Chest Pain)  |      |        |                |
| Heart Attack   |      |        |                |
| Pacemaker  |      |        |                |
| Hypertension   |      |        |                |
| Lung Disease (Asthma, COPD, Cancer)                            |      |        | Specify:       |
| Diabetes   |      |        | Type:          |
| Skin Disorders   |      |        |                |
| Arthritis  |      |        | Type:          |
| Pinched Nerve  |      |        |                |
| Spinal Stenosis  |      |        |                |
| Fibromyalgia   |      |        |                |
| Leg Numbness   |      |        |                |
| Lupus  |      |        |                |
| Anemia   |      |        |                |
| Hepatitis  |      |        | Type:          |
| HIV/AIDS   |      |        |                |
| Clotting Disorder  |      |        |                |
| Anxiety  |      |        |                |
| Depression   |      |        |                |
| Other Psychiatric Disorders                                    |      |        |                |
| Gastric Reflux (GERD)  |      |        |                |
| History of Cancer (Breast, Colon, Prostate, Testicular, Other) |      |        |                |
| Stroke/TIA   |      |        |                |



**AUTHORIZATION TO RELEASE MEDICAL RECORDS**

Name: \_\_\_\_\_ Physical Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I request and authorize \_\_\_\_\_ to release my protected health information as indicated to the organization or Individual name on this request:

- \_\_\_\_\_ All Health Records
- \_\_\_\_\_ Ultrasound Reports
- \_\_\_\_\_ Billing Records
- \_\_\_\_\_ Consent Forms

These records are for services provided on the following date(s): \_\_\_\_\_

Please send the health records listed above to:

Michael Cahn, MD  
4222 Long Beach Rd. SE  
Southport, NC 28461  
Telephone: (910) 363-4949 | Fax: (910) 477-6285

The information may be used and/or disclosed for each of the following purposes:

- \_\_\_\_\_ At my request
- \_\_\_\_\_ For my health care
- \_\_\_\_\_ For payment/insurance
- \_\_\_\_\_ Other (Please describe: \_\_\_\_\_)

This authorization shall expire no later than \_\_\_/\_\_\_/\_\_\_\_\_ and may not be valid for more than one year from date of signature.

I understand that after my health information is disclosed, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I will receive a copy of this authorization after I sign this document. I further understand that I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt of notification by MICHAEL CAHN, MD. By signing below, I represent and warrant that I have authority to sign this document and authorize use or disclosure of protected health information and there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use of disclosure of this protected health information.

Signature of Patient: \_\_\_\_\_ Today's Date: \_\_\_\_\_