Registration Form

Michael L Cahn, MD, PA
611 N Madison St
Whiteville, NC 28472

Referred By ____________________ Primary Care Physician ________________________________

Patient Name ______________________________ Date of Birth ____________________________

Address ____

City ___________________________________ State _______________ Zip Code __________

Home Phone # __________________________ Alternate Phone # ____________________________

Employer ______________________________ Work Phone # __________________________________

SSN _____-_____-_____ Sex M_____ F_____ Marital Status M___ S___ W___ D___

Emergency Contact

Please list any person to whom we may release information to about you in case of emergency:

Name ____________________________ Home Phone # __________________________________

Alternate Phone # ____________________________

Insurance Information

Primary Insurance _______________________ Secondary Insurance ______________________

Subscriber's Name _______________________ Subscriber's Name ________________________

Group/Policy # __________________________ Group/Policy # ___________________________

Financial Agreement

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that I am responsible for all fees and services rendered for treatment of myself or my child. I accept full financial responsibility for all charges not covered by insurance.

I certify that the above information is true and accurate to the best of my knowledge.

Signature __________________________________ Date _____________________

Registration Form

Michael L Cahn, MD, PA
3009 Medical Plaza Lane
Southport, NC 28461

Authorization To Release Medical Information

Please list anyone (family/friend) that you wish to be involved in your care including release of medical information, prescription pickup, etc.

1 ____

2 ____

3 ____

4 ____

5 ____

6 ____

7 ____

8 ____

By signing I authorize the office of Michael L Cahn, MD, PA to release information about my care to the names listed above unless otherwise notified.

Signature ____________________ Date ________________

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Michael L Cahn, MD, PA

3009 Medical Plaza Lane
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Health History

Check symptoms you currently have or have had in the past year

General
__ Chills
__ Depression/Nervousness
__ Dizziness/Fainting
__ Fever
__ Forgetfulness
__ Headache
__ Loss of sleep
__ Loss of weight
__ Numbness
__ Sweats

Muscle/Joint/Bone
Pain/weakness/numbness:
__ Arms __ Hips
__ Back __ Legs
__ Feet __ Neck
__ Hands __ Shoulders

Genito-Urinary
__ Blood in urine
__ Frequent urination
__ Lack of bladder control
__ Painful urination

Gastrointestinal
__ Appetite poor
__ Bloating
__ Bowel Changes
__ Constipation
__ Diarrhea
__ Excessive Thirst
__ Gas
__ Hemorrhoids
__ Indigestion
__ Nausea
__ Rectal Bleeding
__ Stomach pain
__ Vomiting
__ Vomiting blood

Cardiovascular
__ Chest pain
__ High/low blood pressure
__ Irregular/rapid heart beat
__ Poor circulation
__ Swelling of ankles
__ Vericose Veins

Eye, Ear, Nose, Throat
__ Bleeding gums
__ Blurred vision
__ Crossed eyes
__ Difficulty swallowing
__ Double vision
__ Earache/discharge
__ Hay fever
__ Hoarseness
__ Loss of hearing
__ Nose bleeds
__ Persistent cough
__ Ringing in ears
__ Sinus problems
__ Vision (flashes/halos)

Skin
__ Bruises easily
__ Hives
__ Itching/Rash
__ Changes in moles
__ Scars
__ Non-healing sores

Men Only
__ Erectile difficulties
__ Lump in testicles
__ Penile discharge
__ Sore on penis
__ Other ________

Women Only
__ Abnormal Pap Smear
__ Bleeding between periods
__ Breast lump
__ Hot flashes
__ Nipple Discharge
__ Painful intercourse
__ Vaginal discharge
__ Other ________
Date LMP ________
Date last Pap Smear
____
Date last mammogram ________
Pregnant Yes __ No __
children ________

Check conditions you have or have had in the past

__ AIDS
__ Appendicitis
__ Arthritis
__ Asthma
__ Bleeding Disorders
__ Breast Lump
__ Cancer
__ Cataracts
__ Chemical Dependency
__ Chicken Pox
__ Diabetes
__ Emphysema
__ Epilepsy
__ Glaucoma
__ Heart Disease
__ Hepatitis
__ Herpes
__ High Cholesterol
__ HIV positive
__ Kidney Disease
__ Liver Disease
__ Measles
__ Migraine Headaches
__ Multiple Sclerosis
__ Mumps
__ Pacemaker
__ Pneumonia
__ Polio
__ Prostate Problem
__ Rheumatic Fever
__ Scarlet Fever
__ Stroke
__ Thyroid Problems
__ Tuberculosis
__ Ulcers
__ Venereal Disease

Health Habits

Check if you use and how much:
__ Caffeine ________
__ Street Drugs ________
__ Tobacco ________
__ Other ________

Check if your work exposes you to:
__ Stress
__ Heavy Lifting
__ Hazardous Substances
__ Other ________

I certify that the above information is true and accurate to the best of my knowledge.

Signature ________________ Date ________

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Home Medication List

____
____
____
____
____
____
____
____
____
____
____
____

Food Allergies

____
____
____
____

Medication Allergies

1 ____________________ Reaction ____________________
2 ____________________ Reaction ____________________
3 ____________________ Reaction ____________________
4 ____________________ Reaction ____________________
5 ____________________ Reaction ____________________

Pharmacy

Name ____________________ Phone # ____________________

Signature ____________________ Date ____________________

Patient Consent Form

Michael L Cahn, MD, PA
3009 Medical Plaza Lane
Southport, NC 28461

Patient consent for Use/Disclosure of Health Care Information

Patient Name ______________________________ Date of Birth ____________________
Social Security # ______________________________ Previous Name ____________________

I understand that the patient's health information is private and confidential. I understand the Michael L Cahn, MD, PA works very hard to protect patient's privacy and preserve confidentiality of the patient's personal health information.

I understand that Michael L Cahn, MD, PA may use and disclose patient's personal health information to help provide health care to the patient, to handle billing and payments, and to take care of other health care operations. [In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual.]

Michael L Cahn, MD, PA has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy. I understand that I have the right to read the "Notice" before signing this statement.

Under the terms of this consent, I can ask Michael L Cahn, MD, PA to limit how patient's personal health information is used or disclosed to carry out treatment, payment of health care operations. I understand that Michael L Cahn, MD, PA does not have to agree with my request. If Michael L Cahn, MD, PA does not agree with my request, I understand that Michael L Cahn, MD, PA would follow the agreed limits.

I may cancel this consent in writing at any time by doing one of the following:

1) Signing and dating a form the Michael L Cahn, MD, PA can give me called a "Revocation Of Consent for the Use and Disclosure of Health Care Information" or
2) Writing, singing and dating a letter to Michael L Cahn, MD, PA. If I write a letter it must state that I wont to revoke my consent to authorize the use and disclosure of the patient's personal health information for the treatment, payment and health care options.

If I revoke the consent, Michael L Cahn, MD, PA does not have to provide any further health care services to the patient.

My signature below indicates that I have been given a chance to review a current copy of Michael L Cahn, MD, PA's "Notice of Privacy Practices". My signature means that I agree to allow Michael L Cahn, MD, PA to use and disclose the patient's personal health information to carry out treatment, payment and health care options.

Signature ______________________________ Date __________ Time _______