



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): \_\_\_\_\_

\_\_\_\_\_



GENERAL SURGERY 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: \_\_\_\_\_

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: \_\_\_\_\_

<b>CONSENT FOR USE OF WRITTEN TESTIMONIAL, AUDIO, VIDEO AND PICTURE</b>	
INDIVIDUAL'S NAME (PLEASE PRINT)	
<p>I hereby consent to the use of my written testimonials, pictures, voice and/or video recordings for use in any advertising, marketing, publicity, networking or public relations for DoctorCahn.com, Michael L. Cahn, MD FACS DABVLM, and associated brands. I further understand that no royalty, fee or other compensation of any character shall become payable to me by DoctorCahn.com, Michael L. Cahn, MD FACS DABVLM and associated brands. I understand that my consent to use my words, picture, video and/or voice recording is voluntary and my refusal to grant consent will have no effect on any benefits or treatment to which I may be entitled. I further understand that I may at any time exercise the right to cease being filmed, photographed or recorded and may, in writing, rescind my consent for previous materials to be used in future advertising contracts.</p>	
PLEASE CHECK ONE:	
<input type="checkbox"/>	My full name may be used to identify my testimonials, pictures, voice and video.
<input type="checkbox"/>	Only use my first name to identify my testimonials, pictures, voice and video.
<input type="checkbox"/>	Do not use my name to identify my testimonials, pictures, voice and video.
INDIVIDUAL'S SIGNATURE	
DATE	
WITNESS SIGNATURE	
DATE	

\*No pictures or recordings of any type will ever be done without the patient's knowledge and approval.

Check ONLY if refusing:

<input type="checkbox"/>	I DO NOT authorize use of photos or recordings for any purpose.
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