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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:_____

Telephone: (910) 363-4949 Fax: (910) 477-6285
4503 Main Street, Floor 2, Shallotte, NC 28470
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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

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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:

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

_____

_____

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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:** _____

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Vein History

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:

☐ Leg Pain	☐ Burning	☐ Itching	☐ Restless Leg
☐ Aching Legs	☐ Cramps	☐ Tiredness	☐ Discoloration
☐ Throbbing Pain	☐ Swelling	☐ Heaviness	☐ 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?**_____

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(continued from previous page)

□ **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?_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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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			

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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

4503 Main Street, Floor 2, Shallotte, NC 28470

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:_____

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CONSENT FOR USE OF WRITTEN TESTIMONIAL, AUDIO, VIDEO AND PICTURE	
INDIVIDUAL'S NAME (PLEASE PRINT)	
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.	
PLEASE CHECK ONE:	
	My full name may be used to identify my testimonials, pictures, voice and video.
	Only use my first name to identify my testimonials, pictures, voice and video.
	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:

	I DO NOT authorize use of photos or recordings for any purpose.

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