

**David J. Esposito, M.D.**  
**Milford Vascular Institute**  
**20 Commerce Park**  
**Milford, CT 06460**  
**(P) 203-876-9720 (F) 203-822-0384**

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

*\*This form will assist us at Milford Vascular Institute in gathering important information regarding your history. Please take the time to answer each question accurately and completely before you are seen by Dr. Esposito\*.*

**PLEASE PRINT**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Age: \_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

Address: \_\_\_\_\_ Apt #: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_ Zip Code: \_\_\_\_\_

Social Sec #: \_\_\_\_\_ Male \_\_\_ Female \_\_\_ Email Address: \_\_\_\_\_

Home Tel: \_\_\_-\_\_\_-\_\_\_ Cell Ph: \_\_\_-\_\_\_-\_\_\_ Work #: \_\_\_-\_\_\_-\_\_\_

Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_ Tel: \_\_\_-\_\_\_-\_\_\_

Referring Physician: \_\_\_\_\_ Town: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Town: \_\_\_\_\_

Other Physicians you wish to receive information: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Town: \_\_\_\_\_ Tel: \_\_\_-\_\_\_-\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ ID#: \_\_\_\_\_ Grp #: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ ID#: \_\_\_\_\_ Grp #: \_\_\_\_\_

**Current Medications (Prescription and non-prescription):**

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

**Allergies to Food or Medications:**

\_\_\_\_\_ Reaction: \_\_\_\_\_  
\_\_\_\_\_ Reaction: \_\_\_\_\_  
\_\_\_\_\_ Reaction: \_\_\_\_\_

**\*\*PLEASE BRING YOUR INSURANCE CARDS WITH YOU TO YOUR APPOINTMENT\*\***

**Please list all surgeries, hospitalizations, serious illnesses, or accidents:**

1. \_\_\_\_\_ 4. \_\_\_\_\_  
2. \_\_\_\_\_ 5. \_\_\_\_\_  
3. \_\_\_\_\_ 6. \_\_\_\_\_

**Smoking History:**

Have you ever smoked? \_\_\_Yes \_\_\_No      How many packs? \_\_\_\_ How many years? \_\_\_\_\_  
Do you smoke now?     \_\_\_Yes \_\_\_No      How many packs per day? \_\_\_\_  
Do you drink alcohol?   \_\_\_Yes \_\_\_No      How much alcohol do you drink per day? \_\_\_\_\_

**Review of Systems:** Check (√) any condition you have or ever had:

	No	Yes
Hypertension	___	___
Weight Loss	___	___
Changes in Appetite	___	___
Muscle or Bone Pain	___	___
Extreme Fatigue	___	___
Asthma	___	___
Diabetes	___	___
Thyroid Disorder	___	___
Osteoporosis/Osteopenia	___	___
Stroke	___	___
Epilepsy	___	___
Gland Disorder	___	___
Shortness of Breath	___	___
Lung Problems	___	___
Pacemaker Insertion	___	___
Chest Pain/Angina	___	___
Heart Disease	___	___

I authorize Milford Vascular Institute to release any information to expedite insurance claims. I hereby authorize and direct my insurance carrier to pay directly to Milford Vascular Institute any benefits due me under my insurance plan. If my insurance company does not have a contract for full payment for these services, I agree to pay the balance of expenses not paid under my plan. I am herewith supplying all of my insurance information (primary & secondary) to this provider at the time of service.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date