Milford Vascular Institute

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IDENTIFICATION

LAST _____ FIRST _____ M.I. _____

DOB ____/____/____ LEGAL SEX _____ SSN _____-_____-_____

CONTACT INFORMATION

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE NO. _____ CELL PHONE NO. _____

CONSENT TO TEXT? ☐ YES ☐ NO CONSENT TO CALL? ☐ YES ☐ NO

EMAIL _____ ☐ I DO NOT HAVE EMAIL

CONTACT PREFERENCE ☐ TEXT ☐ CALL - HOME PHONE ☐ CALL - CELL PHONE ☐ PATIENT PORTAL ☐ EMAIL

EMERGENCY CONTACT

NAME _____

RELATIONSHIP _____

HOME PHONE NO. _____ CELL PHONE NO. _____

DEMOGRAPHICS

LANGUAGE _____

RACE: ☐ AMERICAN INDIAN ☐ ASIAN ☐ BLACK ☐ HISPANIC ☐ WHITE ☐ OTHER _____

MARTIAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED ☐ PARTNER

HOW DID YOU HEAR ABOUT US? ☐ SPECIALIST PHYSICIAN ☐ PRIMARY CARE PHYSICIAN ☐ FAMILY/FRIEND ☐ SOCIAL MEDIA
☐ GOOGLE/SEARCH ENGINE ☐ ADVERTISEMENT ☐ OTHER _____

CARE TEAM

PRIMARY CARE PHYSICIAN _____

SPECIALIST PHYSICIAN(S) _____

PHARMACY _____ TOWN/ADDRESS _____

PREFERRED LAB _____ TOWN/ADDRESS _____

LIST OF CURRENT MEDICATIONS

MEDICATION	DOSAGE

LIST OF ALLERGIES AND REACTIONS TO MEDICATIONS AND OTHER SUBSTANCES

ALLERGY	REACTION

DO YOU HAVE AN ALLERGY TO THE FOLLOWING:

LATEX: ☐ YES ☐ NO ADHESIVES: ☐ YES ☐ NO BAND-AIDS: ☐ YES ☐ NO

PAST MEDICAL (CHECK ALL THAT APPLY)

- ☐ Anticoagulation Therapy
- ☐ Aneurysm
- ☐ Arrhythmia/A-Fib
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Clot (DVT/PE)
- ☐ Cancer_____
- ☐ Carotid Disease
- ☐ Congenital Heart Disease
- ☐ Congestive Heart Failure
- ☐ COPD/Emphysema
- ☐ Coronary Artery Disease
- ☐ Diabetes (Type 1/Type 2)
- ☐ Epilepsy/Seizures
- ☐ GERD/Reflux
- ☐ Hearing Impaired
- ☐ Heart Attack (MI)
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Migraines/Fainting
- ☐ Pacemaker/Defibrillator
- ☐ Peripheral Arterial Disease
- ☐ Stroke/TIA
- ☐ Thyroid Disease
- ☐ Transplant
- ☐ Ulcers
- ☐ Varicose Veins

SOCIAL HISTORY

DO YOU USE TOBACCO? ☐ CURRENT, EVERYDAY SMOKER ☐ FORMER SMOKER ☐ NEVER SMOKED

IF **YES**, WHAT IS YOUR USAGE PER DAY? _____ WHEN DID YOU START? _____

IF **FORMER**, WHEN DID YOU QUIT? _____

DO YOU USE ALCOHOL? ☐ YES ☐ NO IF YES, HOW MANY DAYS PER WEEK? _____

DO YOU HAVE AN ADVANCED DIRECTIVE? ☐ YES ☐ NO

DO YOU HAVE A MEDICAL POWER OF ATTORNEY? ☐ YES ☐ NO

SURGICAL HISTORY

☐ Varicose Vein Procedures ☐ Other Vascular Surgeries _____

☐ Other Surgeries _____

_____

_____

FAMILY HISTORY (CHECK ALL THAT APPLY & SPECIFY FAMILY RELATION)

☐ Aneurysm _____
☐ Atrial Fibrillation _____
☐ Blood Coagulation Disorder _____
☐ Cancer_____
☐ Coronary Artery Disease _____
☐ Heart Attack (MI) _____
☐ High Blood Pressure _____
☐ High Cholesterol _____
☐ Kidney Disease _____
☐ Liver Disease _____
☐ Lung Disease _____
☐ Peripheral Arterial Disease _____
☐ Stroke/TIA _____
☐ Varicose Veins _____

ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION FOR INSURANCE BILLING

I, _____, hereby authorize Milford Vascular Institute, PC and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws. I understand that I have a right to revoke this authorization by providing written notice to. However, this authorization may not be revoked if, it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority. By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

_____ _____

PATIENT NAME PRINTED DATE

_____

PATIENT SIGNATURE