Milford Vascular Institute

20 Commerce Park
Milford, CT 06460
Office (203) 882-VEIN (8346)
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www.milfordvascular.com

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Interventional Radiology

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Specializing in Minimally Invasive Vein Therapy

Please Print Legibly

Today's date: | PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widow

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	City/State	Zip code:

Social Security no:	Home phone no:	Cell phone no:	Email:

Occupation:	Employer:	Employer phone no.: ( )

Preferred Language:	Race: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Native American ☐ Hawaiian ☐ Other _______________	

Referred to us by (please check one box): ❑ Dr. ______________________ Town _____________

❑ Family ❑ Friend ❑ Close to home/work ❑ Hospital ❑ Yellow Pages ❑ Insurance Plan ❑ Other

Other family members seen here:

What is the reason for your visit today?

Pharmacy:	Town:	Phone: ( )

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate **primary insurance** ❑ Anthem Blue Cross ❑ Aetna ❑ Cigna ❑ Connecticare ❑ CTCare MCR

❑ Harvard Pilgrim ❑ Medicare ❑ Husky Medicaid ❑ Oxford Healthcare ❑ United ❑ Wellcare ❑ Other _____________

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of **secondary insurance** (if applicable)	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

MEDICATIONS

(**Name of Medication / Dose / How many times per day**)

______________________________	______________________________	______________________________
______________________________	______________________________	______________________________
______________________________	______________________________	______________________________

ALLERGIES

(Please list with your reactions)

______________________________	______________________________	______________________________
______________________________	______________________________	______________________________

MEDICAL HISTORY

SELF		FAMILY	SELF		FAMILY	SELF		FAMILY
❑	Aneurysm…………………..	❑	❑	Cholesterol High / Low……..	❑	❑	Kidney Disease…………….	❑
❑	Asthma………………………	❑	❑	Colitis…………………….….	❑	❑	Migraines……………………	❑
❑	Arrhythmia/Atrial Fibrillation	❑	❑	Congestive Heart Failure….	❑	❑	Osteoporosis/Osteopenia…	❑
❑	Arthritis……………………..	❑	❑	Coronary Heart Disease…..	❑	❑	Pacemaker/Defibrillator……	❑
❑	Autoimmune Disease……..	❑	❑	COPD/Emphysema………..	❑	❑	Peripheral/Arterial Disease..	❑
❑	Blood Clots (DVT/ PE)……..	❑	❑	Diabetes…………………….	❑	❑	Pneumonia………………...	❑
❑	Blood Pressure High / Low ..	❑	❑	GERD (reflux)…………..….	❑	❑	Stroke / TIA…………………	❑
❑	Cancer________________	❑	❑	Heart Attack………………..	❑	❑	Thyroid Disease……………	❑
❑	Chemotherapy / Radiation...	❑	❑	Hepatitis…………………….	❑	❑	Varicose Veins……………..	❑

PAST SURGICAL HISTORY

______________________________	______________________________	______________________________
______________________________	______________________________	______________________________
______________________________	______________________________	______________________________

REVIEW OF SYSTEMS

❑ Weight loss	❑ Leg pain with walking	❑ Dizziness
❑ Changes in appetite	❑ Numbness or tingling	❑ Nausea / Vomiting
❑ Extreme Fatigue	❑ Leg swelling	❑ Rash or skin changes
❑ Shortness of breath	❑ Cold extremities	❑ Fevers / Chills
❑ Chest pain	❑ Leg weakness	❑ Back or Neck pain

SOCIAL HISTORY

Do you smoke? ❑ Yes ❑ No How many per day? __________ How many years? ___________ When did you quit? __________

Do you drink alcohol? ❑ Yes ❑ No How many drinks per day? _____________

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
		( )	( )

CONSENT OF COMMUNICATION

I hereby give consent for Milford Vascular Institute to communicate with me by the communication method listed below. I may "opt-out" now or in the future.

Method	Phone Number or Address	Leave a message (yes or no)	
❑ Home Phone………….	________________________	❑ Yes	❑ No
❑ Cell Phone & Text……	________________________	❑ Yes	❑ No
❑ Work Phone…………..	________________________	❑ Yes	❑ No
❑ Alternate Phone……...	________________________	❑ Yes	❑ No
❑ Email ……….. ……….	________________________	❑ Yes	❑ No

I authorize Milford Vascular institute to discuss my health information (which may include history, diagnosis, Lab and test results, treatment, and other health information) with the contacts listed below.

Please fill in person's name in which you give permission to access your records on behalf of you.

I give ____ permission to access to the following information.

❑ Medical Records ❑ Reschedule Appointments ❑ Appointment Information ❑ Financial

I give ____ permission to access to the following information.

❑ Medical Records ❑ Reschedule Appointments ❑ Appointment Information ❑ Financial

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❑ Medical Records ❑ Reschedule Appointments ❑ Appointment Information ❑ Financial

____ ____________________________

Signature Date

HIPAA ACKNOWLEDGEMENT

I understand the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

• Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that directly or indirectly.

• Obtain payment from designated third-party payers.

• Conduct normal health care operations such as quality assessments or evaluations and physician certifications.

I have been informed by MVI of your Notice of Privacy Practices containing a more complete description of the users and disclosures of my health information (available in the office in print form). I have reviewed such Notice of Privacy Practices prior to signing this consent and acknowledge that I have studied the Privacy Practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

____ ____________________________

Patient Name Patient DOB

____ ____________________________

Signature of Patient or Legal Representative Date

_

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AUTHORIZATION TO RELEASE OR OBTAIN MEDICAL RECORD INFORMATION

Patient Name: ___________________________ Date of Birth: _______________________

Maiden Name (optional): __________________ SS#: _______________________________

I hereby authorize Milford Vascular Institute to use, disclose, or obtain the following individually identifiable health information and records as described below.

- ❑ Complete Records
- ❑ Immunizations
- ❑ Pathology Reports
- ❑ Hospital Reports
- ❑ History & Physical
- ❑ Lab Reports
- ❑ Treatment Records
- ❑ Medication Record
- ❑ Care Plan
- ❑ Radiology Reports
- ❑ Operative Reports
- ❑ Other _______________

Please Identify persons/organizations authorized to use or disclose your information:

Name: _________________________________ Phone#: _________________________________

Address: ____

Name: _________________________________ Phone#: _________________________________

Address: ____

Please identify those persons/organizations authorized to receive your information:

Name: _________________________________ Phone#: _________________________________

Address: ____

Name: _________________________________ Phone#: _________________________________

Address: ____

Signature: __________________________________ Date: ________________________