Milford Vascular Institute

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Cardiac, Thoracic, and Vascular Surgery

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Interventional Radiology

KARIN K. AUGUR, PA-C
Specializing in Minimally Invasive Vein Therapy

PATIENT INFORMATION

LAST _____ FIRST _____ M.I. _____

DOB _____/_____/_____ SEX _____ SOCIAL SECURITY NO _____-_____-_____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE NO _____ CELL PHONE NO _____

EMAIL _____ LANGUAGE _____

PREFERRED METHOD OF COMMUNICATION: ☐ Call - Home Phone ☐ Call - Cell Phone ☐ Text - Cell Phone ☐ Email

RACE: ☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ Native American ☐ Hawaiian ☐ Other _____

PRIMARY CARE _____ REFERRING PHYSICIAN_____

PHARMACY_____ ADDRESS/TOWN_____

EMERGENCY CONTACT _____ RELATIONSHIP _____

PHONE NO. _____

CLINICAL INFORMATION

LIST OF ANY CURRENT MEDICATIONS -

MEDICATION **DOSAGE**

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

LIST OF ALLERGIES AND REACTIONS TO MEDICATIONS AND OTHER SUBSTANCES -

_____

_____

_____

LIST OF PAST SURGERIES -

_____

_____

_____

MEDICAL HISTORY - Circle **all** the apply

Aneurysm	Cholesterol High	Kidney Disease
Asthma	Colitis	Migraines / Fainting
Arrhythmia/A-Fib	Congestive Heart Failure	Osteoporosis/Osteopenia
Arthritis	Coronary Heart Disease	Pacemaker/Defibrillator
Autoimmune Disease	COPD/Emphysema	Peripheral Arterial Disease
Blood Clots (DVT/PE)	Diabetes (Type 1 / Type 2)	Pneumonia
Blood Pressure High	GERD (Reflux)	Stroke/TIA
Cancer _____	Heart Attack	Thyroid Disease
Chemotherapy/Radiation	Hepatitis	Varicose Veins

LIST OF IMMEDIATE FAMILY MEMBERS WITH ANY OF THE ABOVE CONDITIONS (Please, state **condition** and **family relation**).

_____

_____

_____

_____

_____

DO YOU USE TOBACCO? ☐ **Current Everyday Smoker** ☐ **Former Smoker** ☐ **Never Smoker**

IF **YES** - HOW MANY?_____ FOR HOW LONG? _____

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

DO YOU USE ALCOHOL? ☐ **Yes** ☐ **No** IF **YES**, HOW MUCH? _____

NO REFERRAL, INSURANCE OR AUTHORIZATION

A referral is an authorization from your primary care physician to allow you to see a specialist for a duration of time, typically 90 days to a year. Not all insurance plans require a referral to see a specialist. If you are unsure if your insurance requires a referral to see Milford Vascular, please contact your insurance provider.

If I do not have a referral from my primary care physician, I agree to be responsible for payment of all expenses incurred from my first date of service. If I cannot produce accurate, updated insurance information for claim submission, I agree to be responsible for payment of all expenses incurred from my first date of service.

If and when I obtain my insurance information or accurate, updated referral information, I will provide this to Milford Vascular Institute.

_____ _____

Print Patient Name **Date**

_____

Signature of Patient or Legal Representative

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.

_____ _____

Print Patient Name **Patient DOB**

_____ _____

Signature of Patient or Legal Representative **Date**