□ Completed □ Medication □ Allergy □ Height/Weight/B.P./HR □ DIAGs

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

Patient Name: _____ Date: _____

Email address_____@_____

Preferred method of communication for patient reminders (circle one): Email / Phone / Mail

DOB: ___/ ___/ ___ **Gender (circle one):** Male / Female **Preferred Language:** _____

Smoking Status (circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity
Race (circle one): White (Caucasian) / Black or African American / American Indian or Alaska Native
Native Hawaiian or Other Pacific Islander / Asian / Other / Decline to Answer

Ethnicity (circle one): Non-Hispanic or Latino / Hispanic or Latino / Decline to Answer

Are you taking any medications? (Please include regularly used over the counter medications)
If you have a med list, we can copy it for you instead

Medication Name	Dosage and Frequency

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

Height_____ Weight_____ Blood Pressure_____/_____ HR_____

□ **I choose to decline receipt of my clinical summary after every visit** (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient Signature: _____ Date: _____