

Electron Health Records Intake Form

Form ID: EHR-INT-001 | Version: 1.0 | Last Updated: 2023-10-27

1. Patient Information
Name: _____
DOB: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____

2. Referral Information
Referring Physician: _____
Referral Date: _____
Referral Reason: _____

3. Insurance Information
Insurance Provider: _____
Policy Number: _____
Group Number: _____

4. Test Information
Test Name: _____
Test Date: _____
Test Location: _____

5. Additional Information
Special Instructions: _____
Other Notes: _____

6. Signature and Date
Submitted By: _____
Date: _____

7. Contact Information
For more information, please contact:
Phone: _____
Email: _____

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name: _____ Last Name: _____

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): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

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: _____

For office use only

Height: _____ Weight: _____ Blood Pressure: _____ / _____