Electronic Health Records Intake Form

In compliance with Medicare requirements for the government EHR incentive program

First Name:________________________ **Last Name**:________________________

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail / Text
Cell phone carrier________________________

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

Family History (Please check)

Is there a family History of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other___________________
Father's side	O	O	O	O	O
Mother's side	O	O	O	O	O

Height ______ **Weight**______ **Last Blood Pressure (if known)** ______

Do you have any medication allergies? Yes / No (If yes, please list below)

Medication Name	Reaction	Onset Date	Additional Comments

Choose one:

- I WOULD like to access my health information electronically.
- I WOULD NOT like to access my health information electronically.

Patient Signature: ____Date:_____________