

# Electronic Health Records Intake Form

*In compliance with requirements for the government EHR incentive program*

**First Name:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_

**Email address:** \_\_\_\_\_@\_\_\_\_\_

**DOB:** \_\_\_/\_\_\_/\_\_\_\_\_ **Gender (Circle one):** Male / Female **Preferred Language:** \_\_\_\_\_

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

**Smoking Start Date (Optional):** \_\_\_\_\_

*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 / 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

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

<b>For office use only</b> Height: _____ Weight: _____ Blood Pressure: _____ / _____
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