



2610 2ND Ave.
Kearney, NE 68847

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

Patient Name (first and last): _____

Email address: _____@_____ Cell Phone Number _____

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

Address: _____ City: _____ State: _____ Zip Code: _____

Occupation _____ Employer _____

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

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

Patient Signature: _____ Date: _____

For office use only			
Height: _____	Weight: _____	Blood Pressure: _____ / _____	Pulse: _____