MILLER WHITMER
FAMILY CHIROPRACTIC

Electronic Health Records Intake Form

In compliance with requirements for the government HER 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

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

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

Do you have any known medication allergies?

Medication Name:	Reaction:	Onset Date:	Additional Comments:

Patient Signature: _____ Date: _____

For office use only

Height _____ Weight _____ Blood Pressure _____/_____

125 Jeff Davis Ave, Long Beach, MS 39560 (228) 868-8885 Fax (228) 868-4991