Miller Chiropractic Health Center
13470 S. Arapaho, Suite 150
Olathe, KS 66062

Electronic Health Records Intake Form

In compliance with Medicare 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/Text

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? ___ Yes ___ No (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? ___ Yes ___ No

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:______ /______