Hawaii Physical Therapy & Chiropractic Clinic, Inc.

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ELECTRONIC HEALTH RECORDS INTAKE FORM

In compliance with requirements for the government EHR incentive program

Name:	Birth Date:	SSN:	
Primary or Cellular No.:	Home No.:	Work No.:	
Mailing Address:	City:	State:	Zip:
Email:	Marital Status: M, S, D, W (Circle One):	Gender: ❑ Male ❑ Female	Student: ❑ FT ❑ PT
Occupation:	Employer: Employer's Address:		
Emergency Contact:	Relationship:	Phone:	

Preferred method of communication for patient reminders (Check One): ❑ Email ❑ Phone ❑ No Reminders Preferred

Insurance Carrier: **Present *ALL* Insurance Cards to Front Office Reception!**

Smoking Status: ❑ Every Day Smoker ❑ Occasional Smoker ❑ Former Smoker ❑ Never Smoked Smoking Start Date (optional):

CMS Requires Providers to Report Both Race and Ethnicity:

Patient's Race: (Check One): ❑ American Indian or Alaskan Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or Pacific Islander ❑ White (Caucasian) ❑ I Decline to Answer

Ethnicity (Check One): ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I Decline to Answer

Preferred Language: ❑ English ❑ Other: _____

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:

Do you have any environmental allergies? ❑ Yes ❑ No If yes, please list:

AGREEMENT:	I understand that I am financially responsible for all charges whether or not paid by said insurance, including deductible, co-payment, and/or non-covered services. I understand that payment is due at the time of service.
AUTHORIZATION:	I authorize the release of any medical information necessary to process my claims, I further authorize payment of insurance benefits directly to Hawaii Physical Therapy & Chiropractic Clinic, Inc. for all services rendered.

Signature: _____ Date: _____

(Patient or Responsible Person, Parent/Guardian)

OFFICE USE ONLY			
Height:	Weight:	Blood Pressure:	Pulse:
Date Scanned into EHR:		Scanned By:	Acct No.: