ELECTRONIC MEDICAL RECORD UPDATE FORM

The federal government has required that we update our records to comply with new regulations. Please take a minute to complete this form and provide us with the necessary information. Thank you.

Patient Information

Name (Please Print):____Date of Birth:_________

MRN# ________________ Race (Optional, circle one): African American Caucasian

Hawaiian Native American Unknown Other:_________________________________

Ethnicity (Optional, circle one or leave blank):

Hispanic/Latino/Spanish origin Non Hispanic/Latino/Spanish origin

Preferred Language (Optional): ____

Tobacco status (Circle one):

Current tobacco user Former tobacco user Never used tobacco

Tobacco currently using or used in the past (Circle all that apply):

Cigarettes Cigars Pipe Chewing tobacco Second hand exposure

Flu vaccine information (Circle one): Flu vaccine administered elsewhere Declined flu vaccine

Not received due to a contraindication to the flu vaccine

Contact Information

Home Phone: ________________ Cell Phone: ________________ Work Phone: _______________

Preferred method of contact (Circle one): Home Phone Cell Phone Work Phone

Preferred Pharmacy Information

Pharmacy Name: ____

Pharmacy Address: ____

Pharmacy Phone: ___________________________ Pharmacy Fax (if known): __________________

By signing below you are allowing your physician to obtain your prescription history. This will keep us better informed of any potential medication issues and enable us to improve safety, quality and care.

Patient Signature: ______________________________________ Date:______________