Completed DX's Entered File #:_____

EHR UPDATE FORM

Please provide insurance card for our office to obtain a new copy.

Name: _____ **Date**:_____

Address: _____ **City:**_____ **State:**_____ **Zip:**_____

Contact number: (_____)_____ **Alt: Phone:**_____

DOB: _____ **Email:** _____

Insurance/New Insurance: Medicare #_____

HMO, PPO Name: _____ Policy: _____

Race: White/Caucasian African American Native American Asian Hawaiian/Pacific Island

Other: _____

Ethnicity: non-Hispanic/Latino Hispanic/Latino

Preferred Language: English Spanish Other: _____

Occupation: _____ or student unemployed retired

How long have you been at your current job? _____

Marital status: Single Married Divorced Widowed Separated

With whom do you currently live?: Alone Spouse/Partner Spouse/Children Other

Smoking Status: Current Former Never

How much?: Light Moderate Heavy

Alcohol Intake: None Casual Moderate Heavy Drinks beer Drinks wine

Caffeine Intake: None <3/day 3-6/day >6/day

Recreational Drugs: None Recreational user Addict

Exercise Frequency: Never Daily Weekly

Type of Exercise?: Walks Runs Swims

Female Patients Only: To the best of your knowledge, are you pregnant? Yes No

Do you have a primary care physician? Yes No Dr.'s name:_____

continued on other side

Please complete the following regarding medications you are taking:

Date Started	Name	Dosage	Frequency

Please list any allergies to medications:

Allergy	Type of Reaction

Please list any surgeries in the past year:

Date (approximate)	Type of Surgery	Hospital

Please list any hospitalizations in the last year, other than surgeries listed above:

Date (approximate)	Reason	Hospital

Please list any major illnesses in the past year (not listed above):

Date (approximate)	Illness

The information given above is accurate to the best of my knowledge.

Signature: _____ **Date:** _____

Office use only
Height: _____ Weight: _____ BP: _____