

Bergen Spine & Rehabilitation, LLC

Wayne M. Poller, DC
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Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name: _____ Last Name: _____

Email address: _____ @ _____ Cell Phone: _____

Cell Phone carrier: _____ (required for receiving text message appt. reminders)

Preferred method of communication for patient reminders (Circle one): Email / Text / Phone / Mail

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 / 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? (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?

Medication Name	Reaction	Onset Date	Additional Comments

FAMILY MEDICAL HISTORY

Disease (family)	Mother/Father	Sibling	Offspring
Example: Heart Disease, diabetes, cancer, etc.	X mother/father	X sister/brother	X son/daughter

*** IS THERE ANY REASON WHY YOU CANNOT RECEIVE ANY TYPE OF ELECTRICAL TREATMENT?

PLEASE EXPLAIN: _____

Height: _____ ft _____ inches Weight: _____ lbs. Blood Pressure: _____ / _____

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: _____