PATIENT INTAKE FORM-2017

Please answer the following questions so we can comply with Medicare at our practice. Please bring this sheet with you into the exam room.

Date_____

Name_____ Date of birth_____

1) Have you ever received the pneumonia vaccine? Yes No

2) Do you smoke? (circle one) Current Former Never

3) Do you have a Advanced Directive (living will)? Yes No

If yes do you have a surrogate decision maker?

Name_____Relationship_____

Thank You!

We now have a secure patient portal to allow patients to access their medical records and communicate with our staff.

Please print clearly the information requested below.

Patient name_____

Patient email address_____

___I do not wish to share my email address.

___I do not have an email address.