

Insurance EHR Update

Date: _____

Patient Name: _____

Home Phone: _____ Cell : _____

E-Mail Address: _____

Current Problem Or Complaint: _____

Smoking: Yes__ No __ Previous __ How Long Ago Did You Quit ____

Medications & Dosage: _____

Prescribed By: _____

Allergies: _____

Height: _____ Weight: _____ Blood Pressure: _____