490 Route 304 | New City, NY 10956 | 845-634-8877 |
info@newcitychiropractic.com | www.newcitychiropractic.com

Attention Patients, **Date**_____________________

All healthcare offices will be required to implement an Electronic Medical Record-keeping system (EMR) mandated by the federal government. In order to fully integrate this system, we are required to obtain the following information. Be secure in the knowledge that this is strictly confidential and will not be shared with anyone without your express written consent.

Thank you for your assistance and cooperation.

Full Name____

E-mail address ____________________________________

Race: ☐ Asian ☐Black ☐Native American ☐White ☐ Other

Ethnicity: ☐Hispanic/Latino ☐Non-Hispanic/Latino

Height_______________________________________

Weight______________________________________

Please list the **names** and **dosages** of any medication you are currently taking:

Name of Medication	Dosage Amount	Times Taken Per Day
______________________________		_______________________
______________________________		_______________________
______________________________		_______________________
______________________________		_______________________

Name of Your Medical Doctor: ____

Are you allergic to any medications? Circle: Yes No

If yes, list them here: ____

Are you a smoker? Circle: Yes No

If yes, how many cigarettes per day? _______________

Have you tried to quit? Circle: Yes No

Thank you again for your cooperation!

For Office Use Only

BP: _____________

WP___
GM___
MC___

Entered in Writepad_____