Certification Information

Dear Patient: US Government is now requiring that we supply them with the following information

Name_____ Date of Birth_____ Chart _____

PRESCRIBED MEDICATION

Please check here if NOT taking ANY PRESCRIBED MEDICATION_____

Medication	#of refills	Quantity of Pills	Strength	Dose Form	MD Instruction
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

Are You Allergic to ANY Medicines?

Check here if you DO NOT have any medicinal allergies_____

	Drug(i.e. Penicillin)	Symptom(i.e. headache)
1		
2		
3		
4		

Please Circle:

Smoking Status: Smokes every day Smokes some days Former Smoker Never Smoked

Ethnicity/Race: Caucasian/White Hispanic/Latino Black/African American Other

Preferred Language: English Spanish German Other

If the Government needs to contact you, how would you like this Confidential Communication to be received? Prefer: Phone Call or Text Message

Phone #_____

Email_____

Mailing Address_____

Have you been diagnosed with : (Please Circle)

Asthma or Diabetes

OFFICE USE-ONLY

Vitals

Blood Pressure _____/_____ Height _____ Weight_____