Annual MIPS Requirement Form

Patient Name:_____ Date of Visit: _____

Date of Birth_____Pharmacy _____

Email (for return visit notifications) _____

Occupation _____
If retired, occupation before you retired _____

Primary Care Provider (Family Doctor) _____

1) Do you have an Advanced Care Plan/Advanced Medical Directive?
Yes_____ No_____ If yes, please bring a copy to place in your chart

Please list who we should contact in case of an emergency. List your decision maker of who will be making medical decisions on your behalf if you are unable to do so

Name:_____
Relationship_____
Phone Number_____

2) Have you received an Influenza immunization in 2019 or 2020? Yes _____ No _____
If yes, date:_____

3) Have you ever received the Pneumococcal vaccine? Yes _____ No _____
If yes, date:_____

4) Have you received a COVID-19 vaccine? Yes _____ No _____
Have you tested positive for COVID-19? Yes _____ No _____

5) Ages 12-20 years old. Do you currently smoke, vape or use any tobacco product?
Yes _____ No _____