

Physician/Practice Information Form

Practice Information

Organization Name (as identified in contract): _____

Organization Type: _____

Private Practice	Critical Access Hospital	Private Practice
Rural Health Center	Public Hospital	Rural Hospital
Community Health Center	Non Priority Hospital	Other Priority Setting

Organization Site: _____

Organization Tax ID: _____

Organization NPI: _____

Organization Address: _____

Is this address the only site? YES NO

EHR Information

Existing EHR? YES NO

Existing EHR Go Live Date: _____

Primary Care EHR (Specify Vendor): _____

Other Primary Care EHR (Specify Vendor): _____

Specialty EHR (Specify Vendor): _____

Other Specialty EHR (Specify Vendor): _____

Practice Management System (Specify Vendor): _____

Primary Care EHR Version: _____

Primary EHR Type: Software as a Service (SaaS) Installed Software

Integrated with PMS? YES NO

Specialty EHR Version: _____

Specialty EHR Type: Software as a Service (SaaS) Installed Software

Specialty Integrated with PMS? YES NO

Practice Demographics

Federally Qualified Health Center? YES NO

of Providers at Site: _____

of Practice Sites: _____

of Support Staff: _____

of Patients: _____

of Patient Encounters Per Year: _____

of Unique Patients Per Year: _____

Patient Demographics

% of Patients on Medicaid: _____

% of Patients on Medicare: _____

% of Patients on Managed Care: _____

% of Patients on Private Insurance: _____

% of Patient Uninsured: _____

Physician Information (include info for each physician in practice)

	Physician Name	NPI	Provider Tax ID	Medical License #	Specialty
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The information collected in this form is required by the office of the National Coordinator for Health Information Technology. It is not legally binding and the information provided should be the physician/practice's best estimate at the time the form is completed.