

Demographic Form

We are required by law to ask patients for the demographic information listed below. **However, you are not required to disclose this information to us.** If you do choose to provide us the information, we will keep your identity confidential.

PATIENT(S)		
1. First Name:	Last:	DOB: / /
2. First Name:	Last:	DOB: / /
3. First Name:	Last:	DOB: / /
4. First Name:	Last:	DOB: / /
5. First Name:	Last:	DOB: / /

DEMOGRAPHIC QUESTIONS
<p>1. Which category best describes the patient's race?</p> <ul style="list-style-type: none"> <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Black or African-American <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Other <p>2. Which category best describes the patient's ethnicity?</p> <ul style="list-style-type: none"> <input type="checkbox"/> Hispanic or Latino or Spanish origin <input type="checkbox"/> Not Hispanic or Latino or Spanish origin <p>3. What is the patient's preferred language?</p> <ul style="list-style-type: none"> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____ <p>4. [] I do not wish to provide this information.</p>

Thank you for your time.