PATIENT DEMOGRAPHICS

PATIENT INFORMATION

PATIENT LEGAL LAST NAME | LEGAL FIRST NAME | MI

NICKNAME | PATIENT DATE OF BIRTH | SEX M F

ADDRESS | CITY, ZIP

PATIENT LIVES WITH ☐ MOTHER ☐ FATHER ☐ BOTH ☐ OTHER ______

PREFERRED CONTACT PHONE # — Please check preferred contact number. ☐ HOME ______ ☐ CELL ______ ☐ WORK ______

PREFERRED LANGUANGE ☐ ENGLISH ☐ SPANISH ☐ OTHER ______

RACE ☐ ALASKA NATIVE ☐ ASIAN ☐ BLACK or AFRICAN AMERICAN ☐ HISPANIC or LATINO ☐ NATIVE AMERICAN
☐ OTHER POLYNESIAN ☐ OTHER RACE ☐ WHITE ☐ DECLINE TO ANSWER

ETHNICIITY ☐ HISPANIC ☐ NON-HISPANIC ☐ OTHER ______ ☐ DECLINE TO ANSWER

CMS requests information on Ethnicity/Race to meet Federal Meaningful Use Criteria

CONTACT INFORMATION

MOTHER/GUARDIAN LAST NAME | FIRST NAME

ADDRESS | CITY, ZIP

DATE OF BIRTH | SSN | EMPLOYER

PREFERRED CONTACT PHONE # — Please check preferred contact number. ☐ HOME ______ ☐ CELL ______ ☐ WORK ______

FATHER/GUARDIAN LAST NAME | FIRST NAME

ADDRESS | CITY, ZIP

DATE OF BIRTH | SSN | EMPLOYER

PREFERRED CONTACT PHONE # — Please check preferred contact number. ☐ HOME ______ ☐ CELL ______ ☐ WORK ______

OTHER CHILDREN IN THE FAMILY

NAME	DOB	NAME	DOB
NAME	DOB	NAME	DOB

______ PARENT/LEGAL GUARDIAN'S SIGNATURE

______ DATE