Patient Demographics

Date_____/_____/__________

Patient Name____

Maiden or Other Name______________________________________

Email Address____
Required for patient portal registration

Address I Street Number____________________________________

City, State and Zip Code____________________________________

Home Phone____________________Mobile________________________Work_____________________

☐ Preferred contact ☐ Preferred contact ☐ Preferred contact

Marital Status (circle one): Single I Married I Separated I Divorced Gender (circle one) Male I Female

Date of Birth_____/_____/__________ Social Security Number________________________________
Required for identification and insurance purposes Required for identification and insurance purposes

Federal health initiatives require us to collect race, ethnicity and language information
If you prefer not to report, you may choose Refuse to report. Please check one per category that applies.

Race: (check one)

- ☐ Asian
- ☐ American Indian or Alaska Native
- ☐ Black/African American
- ☐ Middle Eastern
- ☐ Native American
- ☐ Other Pacific Islander/Native Hawaiian
- ☐ White/European
- ☐ More than one race
- ☐ Refuse to report
- ☐ Other_______________

Ethnicity: (check one)

- ☐ Central American
- ☐ Cuban
- ☐ Dominican
- ☐ Hispanic or Latino / Spanish
- ☐ Latin American / Latin, Latino
- ☐ Mexican
- ☐ Not Hispanic or Latino
- ☐ Puerto Rican
- ☐ South American
- ☐ Spaniard
- ☐ Other_______________________
- ☐ Refuse to report

Preferred Language: (check one) ☐ English ☐ Spanish ☐ Other____________________

Local Preferred Pharmacy I Prescriptions (if prescribed) will be electronically sent to the pharmacy of your choice. Mail order pharmacies see below.

Pharmacy Name____

Address I Street Number____________________________________

City, State and Zip Code____________________________________

Pharmacy Phone____________________Pharmacy Fax____________________

If you are using a **mail order pharmacy** please provide detailed information here: