



## 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 Please check preferred contact number.

CONTACT PHONE #  HOME \_\_\_\_\_  CELL \_\_\_\_\_  WORK \_\_\_\_\_

PREFERRED LANGUAGE  ENGLISH  SPANISH  OTHER \_\_\_\_\_

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

ETHNICITY  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 Please check preferred contact number.

CONTACT PHONE #  HOME \_\_\_\_\_  CELL \_\_\_\_\_  WORK \_\_\_\_\_

FATHER/GUARDIAN LAST NAME	FIRST NAME	
ADDRESS	CITY, ZIP	
DATE OF BIRTH	SSN	EMPLOYER

PREFERRED Please check preferred contact number.

CONTACT PHONE #  HOME \_\_\_\_\_  CELL \_\_\_\_\_  WORK \_\_\_\_\_

### OTHER CHILDREN IN THE FAMILY

NAME	DOB	NAME	DOB
NAME	DOB	NAME	DOB

\_\_\_\_\_  
PARENT/LEGAL GUARDIAN'S SIGNATURE

\_\_\_\_\_  
DATE