



Patient Demographics

Date ____/____/____

Patient Name _____

Maiden or Other Name _____

Email Address _____

Required for patient portal registration

Address | Street Number _____

City, State and Zip Code _____

Home Phone _____ Mobile _____ Work _____

Preferred contact

Preferred contact

Preferred contact

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

Date of Birth ____/____/____ Social Security Number _____

Required for identification and insurance purposes

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

Ethnicity: (check one)

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

Preferred Language: (check one) English Spanish Other _____

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

Pharmacy Name _____

Address | Street Number _____

City, State and Zip Code _____

Pharmacy Phone _____ Pharmacy Fax _____

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