Patient Label

ETHNICITY

☐ Ethnicity disclosure declined by patient

☐ Not Hispanic or Latino

☐ Hispanic or Latino

RACE

☐ Ethnicity not known by patient

☐ Ethnicity disclosure declined by patient

☐ American Indian or Alaska Native

☐ Asian

☐ Black or African American

☐ Native Hawaiian or other Pacific Islander

☐ White

☐ Other

Country of Origin _____

Primary Language _____

Additional Language _____

YOUR INFO

Your Name _____

Appt Date/Time _____

Your Social Security # _____

CONTACT PREFERENCE

☐ By mail ☐ Home Phone

☐ Mobile Phone ☐ Work Phone

☐ Email Address

Please provide your email address for appointment reminders:

_____

If contact preference is a phone number please indicate below if a detailed message can be left with results, response to questions, etc.

☐ Yes ☐ No

PRIMARY CARE PHYSICIAN

Name _____

Location _____

PRIMARY PHARMACY

Name _____

Location _____

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How did you hear about Minnesota Women's Care? Check all that apply:

☐ Physician referral: Doctor's Name & Clinic _____

☐ Friend/family member recommendation: Name:_____

☐ Hospital referral ☐ Google search ☐ Other online search

☐ Facebook ☐ Instagram ☐ Other social media

☐ Saw your building and sign ☐ Read about you in a magazine ☐ Saw an ad

☐ Other _____