

| ETHNICITY | | YOUR INFO | |
|-------------------------------------------|------------------------------------------|--------------------------------------------------------------------------------------------------------|-----------------|
| Ethnicity disclosure declined by patient | | Name | |
| Not Hispanic or Latino | | | |
| Hispanic or Latino | | Phone Number | |
| RACE | | Address | |
| Ethnicity not known by patient | | | |
| Ethnicity disclosure declined by patient | | Social Security # | |
| American Indian or Alaska Native | | Appt Date/Time | |
| Asian | | | |
| Black or African American | | CONTACT PREFER | ENCE |
| Native Hawaiian or other Pacific Islander | | Mobile Phone | ☐ Email Address |
| White | | Home Phone | By Mail |
| Other | | Work Phone | |
| ountry of Origin | | Please provide your email address for appointment reminders: | |
| Primary Language | | | |
| Additional Language | | | |
| | If contact preference is a phone number, | | |
| Primary Care Physician | | please indicate below if a detailed message can be left with results, respond to questions, etc. | |
| Name | | | |
| Location — | | Yes | ☐ No |
| Primary Pharmacy | | | |
| Name | | | |
| Location | | | |