DEMOGRAPHIC INFORMATION REQUEST

We would appreciate your joining our effort to ensure the provision of quality healthcare for all patients by telling us your racial/ethnic background. The choice to supply this information is voluntary.

Patient Name: _____________________ Patient Date of Birth: __________________

1. Please choose the race with which you most closely identify (Check one box)

☐ Black or African American

☐ Asian

☐ White

☐ American Indian or Alaska Native

☐ Native Hawaiian or Other Pacific Islander

2. Please indicate Hispanic or Latino Origin (Ethnicity)

☐ Hispanic or Latino

☐ Not Hispanic or Non-Latino

3. What is your primary language? (Please print)

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