In order to comply with Federal regulations, we have been directed to collect information from our patients on their race, religion and ethnicity. Please select from the following federally approved choices. Thank you in advance for your understanding.

PLEASE PRINT:

Name: _____ Date of Birth: _____

Ethnicity:	Defined as:
_____Hispanic or Latino	A person of Cuban, Mexican, Puerto Rican, Sough or Central American or other Spanish culture or origin, regardless of race.
_____Non Hispanic or Latino	A person NOT of Cuban, Mexican, Puerto Rican, Sough or Central American or other Spanish culture or origin, regardless of race.
_____Decline to Answer	I choose not to answer.

Race:	
_____American Indian or Alaska Native	A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.
_____Asian	A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, or Vietnam.
_____Black or African American	A person having origins in any of the black racial groups of Africa.
_____Native Hawaiian or Other Pacific Island	A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
_____White	A person having origins in any of the original peoples of Europe, the Middle East or North Africa.
_____Decline to answer	

Primary Language:

_____English
_____Spanish
_____Other (Please Specify) _____
_____Decline to answer

Religion:

_____Catholic
_____Jewish
_____Baptist
_____Lutheran
_____Christian
_____Buddhist
_____Other (Please Specify) _____
_____Decline to answer

Signature: ***Date Signed:***