



Demographic Form

In order to ensure the best clinical outcomes as a Patient Centered Medical Home facility, we are required to request the following information:

- | | |
|---------------------|-----------------------|
| 1) Ethnicity | 4) Disability Status |
| 2) Race | 5) Gender Identity |
| 3) Primary language | 6) Sexual Orientation |

Please provide the following information:

Ethnicity:

- Hispanic/Latino
 Not Hispanic/Latino

Race:

- | | |
|--|---|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> White and/or Caucasian |
| <input type="checkbox"/> Asian | <input type="checkbox"/> More than one race |
| <input type="checkbox"/> Black and/or African American | <input type="checkbox"/> Other. Please specify: _____ |
| <input type="checkbox"/> Native Hawaiian or Pacific Islander | |

Primary Language:

Disability Status:

Gender Identity:

Sexual Orientation:

- | | |
|---|---|
| <input type="checkbox"/> Straight/Heterosexual | <input type="checkbox"/> Something Else |
| <input type="checkbox"/> Gay/Lesbian/Homosexual | <input type="checkbox"/> Don't Know |
| <input type="checkbox"/> Bisexual | <input type="checkbox"/> Choose Not to Disclose |

You have the right to refuse to disclose and/or provide the above requested information. This refusal will not affect your status as a patient or the care provided to you. If you so desire, please indicate such refusal below.

- I hereby decline to disclose the information requested on this form.

Thank you for your cooperation.

Patient Name: _____

Date of Birth: _____