Patient Information

Last Name:	First Name:

Race: **(Select one or more)**	☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐Native Hawaiian or Other Pacific Islander ☐White ☐Decline
Ethnicity:	☐Hispanic or Latino ☐Not Hispanic or Latino ☐Decline
Religion:	
Preferred Language:	
Marital Status:	
Occupation:	
Education Level:	☐None ☐Elementary ☐High School ☐Associates Degree ☐Bachelors Degree ☐Masters Degree ☐Doctorate ☐Decline
Present Employer:	

Patient's Signature:	Date: