

Patient Name: _____

DOB: _____

MRN: _____

This classification provides a minimum standard for maintaining, collecting and presenting data on race and ethnicity for all Federal reporting purposes. Refusal to complete this form does not in any way impact your treatment as a patient. This is for Federal reporting purposes only. This is not to be used as determinants of eligibility for participation in any Federal Program.

Race: (select one or more)

_____ 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 Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.

_____ Black or African American – A person having origins of any of the black racial groups of Africa.

_____ White – A person having origins in any of the original peoples of Europe, the Middle East, or North America.

_____ Declined

Ethnicity: (select one)

_____ Hispanic or Latino – A person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish Culture or origin, regardless of race. The term “Spanish origin” can be in addition to “Hispanic or Latino.”

_____ Non-Hispanic or Latino

_____ Declined

Preferred Language: _____

Patient Signature: _____

Date: _____