EAGLE PHYSICIANS

PATIENT NAME: _____
LAST FIRST MIDDLE

HOME ADDRESS _____
STREET APT #/LOT #

_____
CITY STATE ZIP

SEX: ❑ **MALE** ❑ **FEMALE** **HOME PHONE #** _____ **CELL PHONE #** _____

EMAIL ADDRESS: _____

PATIENT'S DATE OF BIRTH _____ **SOCIAL SECURITY #** _____
MONTH DAY YEAR

MARITAL STATUS: ❑ SINGLE ❑ MARRIED ❑ DIVORCED/SEPARATED ❑ WIDOWED ❑ SIGNIFICANT OTHER

EMPLOYER'S NAME _____ OCCUPATION _____

WORK PHONE # _____ DRIVER'S LICENSE # _____ STATE _____

IF PATIENT IS A MINOR:

PARENT/GUARDIAN'S NAME _____
LAST FIRST MIDDLE

PARENT/GUARDIAN'S HOME ADDRESS _____
STREET APT # / LOT #

_____
CITY STATE ZIP

HOME PHONE # _____ WORK PHONE # _____

IF PATIENT IS MARRIED:

NAME OF SPOUSE _____
LAST FIRST MIDDLE

SPOUSE'S DATE OF BIRTH _____ SPOUSE'S SOCIAL SECURITY # _____
MONTH DAY YEAR

SPOUSE'S EMPLOYER _____ OCCUPATION _____

SPOUSE'S WORK PHONE # _____

EMERGENCY CONTACT: _____ PHONE # _____
NAME/RELATIONSHIP

EAGLE PHYSICIANS

To meet requirements associated with the American Recovery and Reinvestment Act (ARRA) as it relates to meaningful use of an electronic medical record, Eagle Physicians is required to gather some additional demographic data from you. This information will be recorded in your electronic chart to help Eagle continue improving our service for you.

Please write in your name and date of birth below and then check the appropriate boxes for race, ethnicity and preferred language.

After completing the form, please hand it back to our front desk staff and we'll record the new information in your record.

Thank you for your assistance.

Patient Name:_____

Date of Birth:_____

Race:

- o American Indian or Alaska Native
- o Asian
- o Native Hawaiian
- o Black or African American
- o White
- o Hispanic
- o Other Race
- o Other Pacific Islander
- o Decline to Report

Ethnicity:

- o Hispanic
- o Non-Hispanic
- o Decline to Report

Preferred Language:

- o Arabic
- o Chinese
- o English
- o French
- o German
- o Greek
- o Hindi
- o Indian (incl Hindi and Tamil)
- o Italian
- o Japanese
- o Other

(Please list:_____)

Any Special Communication Needs:

Please list:_____