Patient Questionnaire

Patient Name: ________________________________ Date: ___/___/___
Primary Language Spoken:____________________

Preferred Means of Communication <u>for Appointment Verification</u>:
(PLEASE CHOOSE 1 OPTION ONLY)

1. Phone Call Home #: (___)____-______ Cell #: (___)____-______

OR

2. Email Email Address: ________________________________

OR

3. Text Message- **(If this is your preferred method of communication please be sure to provide carrier information)**

Cell #: (___) ____-______ Carrier: ______________________

RACE: (please check one)

(__) Caucasian
(__) Latino
(__) African American
(__) Asian
(__) Pacific Islander
(__) American Indian
(__) Decline
Other: __________________________

ETHNICITY: (please check one)

(__) Hispanic or Latino
(__) Asian
(__) African American
(__) Caucasian
Other: ___________________________

How were you referred?

(__) Google
(__) Website
(__) Zocdoc
(__) Newspaper
(__) Other__________________

PHARMACY NAME: ______________________ PHONE #: (____) _____-________
(REQUIRED**) PHARMACY ADDRESS:_______________________________________

Patient Signature or Legal Guardian: ___________________________________