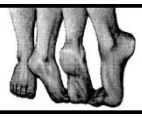

EAST OCEAN PODIATRY **PATIENT DEMOGRAPHICS**

We are asking for your race and ethnicity because some people have higher risks of developing certain disease, such as high blood pressure, diabetes, and heart disease. It is also important that we know your preferred spoken language so that you and your health care team can communicate clearly.

We will keep this information confidential (private) and will update it in your medical record. This information will assist us in continuing to provide you with the best health care.

Please fill in the information below. We greatly appreciate your participation. Thank You in advance

PATIENT NAME: _____

Race. Please mark what best describes you.
(Please mark only ***ONE*** race.)
□ American Indian/ Alaska Native
□ Asian
□ Black/ African American
□ Native Hawaiian/ Pacific Islander
□ White/ Caucasian

Language. Please mark what best describes you.
(Please mark only ***ONE*** primary language.)

□ English □ Spanish
□ French □ Russian
□ Italian □ Dutch
□ Chinese □ Japanese

Are you of Hispanic Origin?
(Please mark ***ONE*** statement that best describes you.)

□ Hispanic or Latino
□ No, not Hispanic/ Latino
□ I prefer not to answer

Please Check ***ANY*** that apply to you.

Specific Allergies: □ Baker's Yeast □ Eggs □ No

Could ***you*** be pregnant? □ Yes □ No

Are ***you*** a smoker? □ Former □ Never □ Current

Do ***you*** have any terminal illnesses? □ Yes □ No

To provide you with the best care, we are now able to provide you with your medical records online and also electronically prescribe your medications. To be able to do so we Need your cooperation in providing us with your e-mail and pharmacy information. If you do not know the exact address or phone number to your pharmacy please provide the pharmacies cross streets.

Patient E-mail: _____

Preferred Pharmacy Name: _____

Pharmacy Phone Number: _____

Pharmacy Fax Number: _____

Pharmacy Address: _____
(or cross streets) _____

Patient Signature: _____ Date: _____