INFORMATION UPDATE

Please choose only ONE answer for each question unless otherwise noted. All information is kept strictly confidential.

Appointment Date:	**Appointment Time:**

PATIENT (CONTACT) INFORMATION

Patient Name: *(First MI Last)*		**PAD (Alt ID) #:**		**Preferred Method:**
Address:		**Home Phone:**		☐
City:		**Cell Phone:**		☐
State:		**Mail:**		☐
Zip:				
Emergency Contact		**INSURANCE?** ☐ Yes	☐ No	
Name:		☐ Private Insurance		
Phone:		☐ Medicaid		

DEMOGRAPHIC INFORMATION

Date of Birth: (Month/Day/Year)					
Race/Ethnicity:	☐ White	☐ White/Hispanic	☐ Non- White Hispanic	☐ Black/Hispanic	☐ African American
	☐ American Indian or Alaskan Native		☐ Asian Indian	☐ Chinese	☐ Filipino	☐ Japanese
	☐ Korean	☐ Vietnamese	☐ Other Asian	☐ Native Hawaiian	☐ Guamanian or Charmono	☐ Samoan
	☐ Other Pacific Islander		☐ Biracial/Multiracial		☐ Other	☐ Unknown/Unspecified
Primary Language:	☐ English	☐ Spanish	☐ Vietnamese	☐ Chinese	☐ French	☐ Other

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