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: _____