JERICHO ROAD COMMUNITY HEALTH CENTER

Patient Information Form

Patient First Name: _____ **Patient Last Name:** _____ **Date of Birth:** _____

Email Address: _____

Race (Circle one)

White Black/African American Asian American Indian/Alaska Native

Native Hawaiian/Other Pacific Islander All Other Races Declined to Specify/Unknown

Ethnicity (Circle one)

Not Hispanic/Latino Hispanic/Latino Declined to Specify/Unknown

Language: _____

Sex at Birth (Circle one) Male Female

Sexual Orientation (Circle one)

Straight or heterosexual Lesbian, gay, or homosexual Bisexual Queer Asexual

Pansexual Don't know Declined to Specify None

Something else, please describe: _____

Gender Identity (Circle one)

Male Female Transgender male Transgender female

Neither exclusively male nor female Not sure/Questioning Declined to Specify None

Additional gender category/other, please specify: _____

Household Annual Income: _____ **Household Size:** _____

Special Population (Circle all that apply)

Agricultural Worker Homeless School-Based Veterans

Public Housing Immigrant Refugee

Patient Signature: _____ **Date:** _____

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