JERICHO ROAD COMMUNITY HEALTH CENTER

Patient Information Form

Patient First Name: ________________________ **Patient Last Name:** ___________________________ **Date of Birth:** ___________

Email Address: ____ **SS #:** _____________________________

Race (Circle one):

White Black/African American American Indian/Alaska Native Native Hawaiian/Other Pacific Islander

Filipino Chinese Japanese Korean Vietnamese Other Asian Guamanian or Chamorro Samoan

All Other Races Declined to Specify/Unknown

Ethnicity (Circle one):

Mexican American Chicano/a Puerto Rican Cuban Hispanic

Non Hispanic/Latino Declined to Specify/Unknown

Language: ____ **(Fill in the language you speak)**

Sex at Birth (Circle one): Male Female

Household Annual Income: ________________________ **Household Size:** ________________________

Billing Statement Preference (Circle one): Text Email Mail

Special Population (Circle all that apply):

Agricultural Worker Homeless School-Based Veterans

Public Housing Immigrant Refugee

Patient Signature: ____ **Date:** _____________________

Reviewed By: ____

Entered By: ____