DUPAGE PEDIATRICS LTD 5.7.14

Health Care Reform is requesting the following information. Thank you for your cooperation.

Patient Name:____

Siblings this information applies to:

____

____

E-Mail____

By providing an email address you give DuPage Pediatrics permission to contact you by email

PLEASE CHOOSE AN ANSWER IN EACH OF THE 3 SECTIONS BELOW

Ethnicity:

- ◯ Hispanic or Latin
- ◯ Non Hispanic or Latin
- ◯ Refuse to Report

Race:

- ◯ American Indian or Alaska Native
- ◯ Asian
- ◯ Black or African American
- ◯ White
- ◯ Hispanic
- ◯ Other Race
- ◯ Refused to Report

Primary Language:

- ◯ English
- ◯ Indian (Includes Hindi)
- ◯ Spanish
- ◯ Chinese
- ◯ Other ___________________________
- ◯ Refused to Report

Signature:____ Date:_______________________