DUPAGE PEDIATRICS LTD 5.7.14

Health Care Reform is requesting the following information. <u>Thank you</u> 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

<u>PLEASE CHOOSE AN ANSWER IN EACH OF THE 3 SECTIONS BELOW</u>

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:_____