

## DUPAGE PEDIATRICS, LTD PATIENT DEMOGRAPHIC INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Names of Siblings This Information Applies To: \_\_\_\_\_

Email Address: \_\_\_\_\_

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

**PLEASE CHOOSE AN ANSWER FOR EACH OF THE 3 SECTIONS BELOW:**

### ETHNICITY:

Hispanic/Latino

Non-Hispanic/Latino

Decline to Specify

### RACE:

White

Black

American Indian/Alaska Native

Asian

Native Hawaiian and Other Pacific Islander

Other Race: \_\_\_\_\_

Decline to Specify

### PREFERRED LANGUAGE:

English

Spanish

Arabic

Chinese

Polish

Other Language: \_\_\_\_\_

Decline to Specify

Signature: \_\_\_\_\_ Date: \_\_\_\_\_