DUPAGE PEDIATRICS LTD 6/20/2019

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
- ◯ Declined to Specify

Race:

- ◯ American Indian or Alaska Native
- ◯ Asian
- ◯ Black or African American
- ◯ White
- ◯ Hispanic
- ◯ Other Race ______________________
- ◯ Declined to Specify

Primary Language:

- ◯ English
- ◯ Hindi
- ◯ Spanish
- ◯ Chinese
- ◯ Other ________________________
- ◯ Declined to Specify

Signature:____ Date:____________________