

PATIENT REGISTRATION

(THIS FORM IS REQUIRED BY THE FEDERAL GOVERNMENT)

Patient Name: _____

Date: _____

1). Language Spoken: _____

DOB: _____

2). Race:

- C Caucasian
- B Black
- H Hispanic
- A Asian
- G Native American
- F Asian Pacific American
- P Pacific Islander
- D Subcontinent Asian American
- I American Indian or Alaskan Native
- J Native Hawaiian
- N Black Non-Hispanic
- O White Non-Hispanic
- E Other Race or Ethnicity
- M More than One Race
- N1 Race Not Reported –Refusal
- N2 Race Not Reported – Don't Know
- N3 Race Not Reported – Not Ascertained

3). Ethnicity:

- L Latino/Hispanic
- O Other
- N Not Reported/ Refused

4). Marital Status:

- S Single
- M Married
- D Divorced
- W Widowed
- X Legally Separated
- U Unknown
- O Other
- C Child