

*In order to comply with the new Health Care Mandates, Pacific Women's Center is required to collect the following information. It is intended to be a major step in enhancing the ability to monitor health care processes and outcomes for different population groups, target quality initiatives more efficiently and effectively, and provide patient-centered care.*

Name (Please Print): \_\_\_\_\_ DOB: \_\_\_\_\_

<b>RACE</b> (select all that apply)			
<input type="radio"/> American Indian or Alaska Native	<input type="radio"/> Asian	<input type="radio"/> Black/African American	
<input type="radio"/> Pacific Islander	<input type="radio"/> White/Caucasian	<input type="radio"/> Decline to Specify	
<b>ETHNICITY</b> (choose only one)			
<input type="radio"/> Hispanic or Latin	<input type="radio"/> Non-Hispanic or Latin	<input type="radio"/> Decline to Specify	
<b>PREFERRED LANGUAGE</b> (choose only one)			
<input type="radio"/> Arabic	<input type="radio"/> Asian Indian	<input type="radio"/> Chinese	<input type="radio"/> English
<input type="radio"/> Japanese	<input type="radio"/> Korean	<input type="radio"/> Spanish	<input type="radio"/> Other _____

**Referred By:**     Doctor     Family     Friend     Insurance     Internet     Other

**Preferred Pharmacy & Location:** \_\_\_\_\_

**Patient/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_