Medical Pavilion Clinic

2525 Harbor Blvd. Port Charlotte, Fl. 33952
(941) 629-9190

Date: ____/____/____

_____
First Name Middle Name Last Name

Date of Birth:_____

Social Security Number: _____

Male: _____Female:_____

Marital Status: _____

Employment Status: _____

Occupation: _____

Permanent Address:

_____
Address Street Apartment PO Box Number

_____
City State Zip Code

Home Phone: _____

Cellular Phone: _____

Work Phone_____

E-mail Address: _____

Local Address:

_____
First Name Middle Name Last Name

_____
Address

_____
Local Phone Number

Preferred Pharmacy:

_____
Name

_____
Address

_____
Phone Number

Emergency Contact:

_____
First Name Middle Name Last Name

_____
Address

_____
City State Zip Code

_____
Phone Number

Relation to Patient: _____

Patient Name: _____
Last First

Information we are required to ask:

We are required by the **FEDERAL GOVERNMENT** to ask and collect information on race, ethnicity, sexual identification, gender orientation and language preferences. We appreciate you providing us with this information.

Race:

- ☐ **American Indian or Alaska Native**
- ☐ **Asian**
- ☐ **Black or African American**
- ☐ **Native Hawaiian or Other Pacific Islander**
- ☐ **White**
- ☐ **Other**
- ☐ **Unreported/ Refused to Report**

Ethnicity:

- ☐ **Latin/Hispanic**
- ☐ **Not Latin/ Not Hispanic**
- ☐ **Decline**

Language Preference: _____

- ☐ Decline

Sexual Identification:

- ☐ **Straight or Heterosexual**
- ☐ **Lesbian, Gay, or Homosexual**
- ☐ **Bisexual**
- ☐ **Something else, please describe**
- ☐ **Don't Know**
- ☐ **Decline**

Gender Orientation:

- ☐ **Male**
- ☐ **Female**
- ☐ **Transgender male/ Trans man/ Female-to-male**
- ☐ **Transgender female/ Trans woman/Male-to-female**
- ☐ **Genderqueer, neither exclusively male nor female**
- ☐ **Additional gender category/ (or other), please specify**
- ☐ **Decline**