The information below is required by the new CMS guidelines. Thank you for your cooperation.

What is your primary preference of contact? Please check one of the following:

☐ Home (_____) _____ ☐ Daytime (_____) _____

☐ Cell Phone (_____) _____ ☐ Evening (_____) _____

☐ Work (_____) _____ ☐ Emergency (_____) _____

Would you like to set up a patient portal where you could view your personal information? For example; labs, progress notes, and medication lists. If so, please give us your email address and we will give you a personal PIN to establish a secure connection.

Email address: _____ ☐ Decline patient portal

What is your race/ethnicity?

Non-Hispanic

☐ White/Caucasian

☐ Black/ African American

☐ Asian (specify)_____

☐ Pacific Islander

☐ American Indian or Alaskan Native

☐ Other _____

☐ Decline ethnicity

Hispanic

☐ Mexican American

☐ Mexican

☐ South American

☐ Other _____

What is your primary language? _____

What is your pharmacy preference? Please list name of pharmacy, phone number, and address below.

Pharmacy Name: _____ Phone Number: _____

Address: _____

Signature: _____ Date: _____

Patient Name: _____