Preferred Language

Patient name : ______________________ ______________________ ______________________
First name Mid name Last name

Your birthday : ___/___/_________ Preferred Contact Method : ☐ Phone ☐ Email

Preferred Language: ☐ English ☐ Spanish ☐ Other ____

Race : ☐ White ☐ Black/African American ☐ Asian ☐ American Indian or Native Alaskan ☐ Native Hawaiian/Pacific Islander ☐ Unknown

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unknown

Pharmacy Name: ____ Phone no : (____) - ____ - ____

Street: ____ Zipcode: ____________

Print Name : ____

Signature : ______________________________ Date : ____________