*We want to make sure that all our patients get the best care possible. We would like you to tell us your Country of origin, racial/ethnic background, so that we can review the treatment that all patients receive and make sure that everyone gets the highest qualify of care. Your answers will be confidential and will have no effect on the care your receive.*

| ETHNICITY – PLEASE CIRCLE YOUR ETHNICITY |
|---|
| Hispanic or Latino |
| Non Hispanic/Latino |

| RACE - PLEASE CIRCLE YOUR RACE |
|---|
| White |
| **Black** (includes Black, African American, African, Ethiopian, Ghanaian; Haitian, Cape Verdean, West Indian, Nigerian, Other African) |
| **Native Hawaiian/Pacific Islander** (includes Native Hawaiian, Pacific Islander, Guamanian) |
| American Indian or Alaskan |
| **Asian** (includes Chinese, Cambodian, Hmong, Indian, Filipino, Laotian, Other Asian) |
| Multi Racial |
| White and Black |
| White and Asian |
| White and American Indian or Alaskan |
| White and Native Hawaiian/Pacific Islander |
| Black and Asian |
| Black and American Indian or Alaskan |
| Black and Native Hawaiian/Pacific Islander |
| Asian and American Indian or Alaskan |
| Asian and Native Hawaiian/Pacific Islander |
| Other |

Registrar's SMS ID_____

Every patient is to complete this form once. Registrar will scan form into DI.