PATIENT INFORMATION (PLEASE PRINT) TODAY'S DATE ___/___/_____

Name ______________________________________ Social Security Number _____-___-______

Mailing Address ____
City State Zip

Home Phone _________________ Cell Phone ________________ Date of Birth ___/____/____

Sex M/F Marital Status M/S/D/W E-mail Address _____________________________________

Employer ____ Work # _____________________

Spouse's Name: ____ Date of Birth _____/____/______

Employer: ____ Work # _________________________

RESPONSIBLE PARTY (If different above)
Name: ____________________________________ Date of Birth: ___/___/___ Sex M/F

Address: ____
City State Zip

INSURANCE INFORMATION **(please present Insurance card at time of check in.)**
Please check if you have one of the following ( ) PMD ( ) Medicare ( ) Medicare Complete ( ) Commercial ( ) UMWA
( ) Cigna ( ) United Healthcare ( ) Other

Primary Insurance ___________________________ **Secondary Insurance ____________________**

Name of Insured _____________________________ Name of Insured _________________________

ID Number _________________________________ ID Number _____________________________

Group Number _________________________ Group Number __________________________

****

Pharmacy ____________________________________ Phone number _______________________

ARE YOU ALLERGIC TO ANY MEDICATIONS? ______ IF YES WHAT __________________
____

In care of Emergency who should we notify? _________________________ Phone _________________

I authorize the release of medical information to my physicians, and insurance carriers. I also authorize my pharmacy to release any information regarding my prescription history, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician. Agreement: I, the undersigned (patient or legal guardian), authorize medial treatment to be rendered by Dr. McLain and staff, and assume financial responsibility. In the event the account is not paid in full within 90 days, the undersigned agrees to pay all costs of collection including reasonable attorney fees, and hereby waive all rights of exemption under the constitution and laws of the state of Alabama.

____ **Date** _____/_____/_____
Signature of Patient or Legal Guardian

DATE: ENCOUNTER #

Please select the ONE best answer for your abilities at this time: NAME____________________

OVER THE LAST WEEK, were you able to:	Without any Difficulty	With Some Difficulty	With much Difficulty	Unable Difficulty
Dress yourself including tying shoelaces and doing buttons?	❍	❍	❍	❍
Get in and out of bed:	❍	❍	❍	❍
Lift a full cup or glass to your mouth?	❍	❍	❍	❍
Walk outdoors on flat ground?	❍	❍	❍	❍
Wash and dry your entire body?	❍	❍	❍	❍
Bend down to pick up clothing from the floor?	❍	❍	❍	❍
Turn faucets on and off?	❍	❍	❍	❍
Get in and out of a car, bus, or airplane?	❍	❍	❍	❍
Walk two miles if you wish?	❍	❍	❍	❍
Participate in recreational activities and sports, if you wish?	❍	❍	❍	❍
Get a good night's sleep?	❍	❍	❍	❍
Deal with feelings of anxiety or being nervous?	❍	❍	❍	❍
Deal with feelings of depression or feeling blue?	❍	❍	❍	❍

HOW MUCH PAIN HAVE YOU HAD BECAUSE OF YOUR CONDITION OVER THE PAST WEEK?

Please indicate how severe your pain has been:

NO	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	Severe
Pain	**0**	**0.5**	**1**	**1.5**	**2**	**2.5**	**3**	**3.5**	**4**	**4.5**	**5**	**5.5**	**6**	**6.5**	**7**	**7.5**	**8**	**8.5**	**9**	**9.5**	**10**	**Pain**

Please check in the appropriate spot to indicate the amount of pain you are having TODAY in each of the joint areas listed below:

	NONE	MILD	MODERATE	SEVERE		NONE	MILD	MODERATE	SEVERE
LEFT FINGERS	❍	❍	❍	❍	RIGHT FINGERS	❍	❍	❍	❍
LEFT WRIST	❍	❍	❍	❍	RIGHT WRIST	❍	❍	❍	❍
LEFT ELBOW	❍	❍	❍	❍	RIGHT ELBOW	❍	❍	❍	❍
LEFT SHOULDER	❍	❍	❍	❍	RIGHT SHOULDER	❍	❍	❍	❍
LEFT HIP	❍	❍	❍	❍	RIGHT HIP	❍	❍	❍	❍
LEFT KNEE	❍	❍	❍	❍	RIGHT KNEE	❍	❍	❍	❍
LEFT ANKLE	❍	❍	❍	❍	RIGHT ANKLE	❍	❍	❍	❍
LEFT TOES	❍	❍	❍	❍	RIGHT TOES	❍	❍	❍	❍
NECK	❍	❍	❍	❍	Back	❍	❍	❍	❍

Considering all the ways in which illness and health conditions may affect you at this time please indicate how you are doing:

VERY	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	VERY
WELL	**0**	**0.5**	**1**	**1.5**	**2**	**2.5**	**3**	**3.5**	**4**	**4.5**	**5**	**5.5**	**6**	**6.5**	**7**	**7.5**	**8**	**8.5**	**9**	**9.5**	**10**	**POOR**

Please check below if you have experienced any of the following in the last months: ❍ **NONE**

❍ Fever	❍ Problem with Hearing	❍ Vomiting	❍ Joint Pain
❍ Weight Gain	❍ Ringing in the Ears	❍ Constipation	❍ Back Pain
❍ Weight Loss	❍ Stuffy Nose	❍ Diarrhea	❍ Neck Pain
❍ Feeling Sickly	❍ Sores in Mouth	❍ Dark or Bloody Stools	❍ Use of drugs not sold in stores
❍ Headaches	❍ Dry Mouth	❍ Problems with Urination	❍ Smoking Cigarettes
❍ Unusual Fatigue	❍ Problems with smell or taste	❍ Gynecologic Problems	❍ More than 2 Alcoholic drinks/day
❍ Swollen Glands	❍ Lump in Throat	❍ Dizziness	❍ Depression
❍ Loss of Appetite	❍ Cough	❍ Losing your Balance	❍ Anxiety
❍ Skin Rash	❍ Shortness of Breath	❍ Muscle Pain, Aches, or Cramps	❍ Problems with Thinking
❍ Hives	❍ Wheezing	❍ Muscle Weakness	❍ Problems with Memory
❍ Easy Bleeding	❍ Pain in Chest	❍ Paralysis of Arms or Legs	❍ Problems with Sleeping
❍ Easy Bruising	❍ Heart Pounding (palpitations)	❍ Numbness/Tingling of Arms or Legs	❍ Sexual Problems
❍ Other Skin Problems	❍ Trouble Swallowing (dysphagia)	❍ Fainting Spells (syncope)	❍ Burning in Sex Organs
❍ Loss of Hair	❍ Heartburn	❍ Swelling of Hands	❍ Problems with Social Activities
❍ Dry Eyes	❍ Stomach Pain or Cramps	❍ Swelling of Ankles	
❍ Other Eye Problems	❍ Nausea	❍ Swelling in Other Joints	

MEDICAL HISTORY FORM

Patient Name: ______________________ DOB: ______/______/_______

Signature: _________________________ Date: _____/______/________

Present Health Concerns: ____

MEDICATIONS: *Please list all prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs etc.*

Medication Name	Dose	Frequency

ALLERGIES: *List all reactions to medicines, foods and other agents.*

Allergy	Reaction or Side Affect

PERSONAL MEDICAL HISTORY: *Please indicate whether you have had any of the following medical problems.*

Congenital Heart Disease:
please specify:__________________
Myocardial Infarction (Heart Attack)
Hypertension (High Blood Pressure)
Diabetes
High Cholesterol

Cancer (Malignancy)
please specify:_________________
Stroke
Coagulation (Bleeding/Clotting)
Depression/Suicide Attempt
Alcoholism

Hepatitis A, B, or C (*specifiy)*_______
Date of Last Colonoscopy: _____________
Date of last Tetanus Shot: _____________
Date of last HIV Test: _________________
Date of Blood Transfusion: ____________
Other:_______________________________

SURGICAL HISTORY: *Please list all prior surgeries and dates.*

Surgery	Date

IMMUNIZATIONS: *Please list your most recent immunizations, not including those administered at Lowell General Hospital. Please include your best estimate of the month and year of each immunization.*

Hepatitis A: __________ Measles: ____________ Mumps: _____________ Rubella: _____________ MMR: _______________
Hepatitis B: __________ Pneumovax: _________ Tdap: _______________ Varicella: ____________ Other: ______________

WOMEN'S HEALTHY GYNECOLOGIC/OBSTETRIC HISTORY: *(For Women Only)*

# of Pregnancies: ______ # of Deliveries: ______ # of Abortions: ______ # of Miscarriages: _____ Age at 1st menses: ___
Frequency of menses: _______ Length of menses: ______ Date of last menses: ________ Date of last mammogram: _______

Do you have any concerns about your period or menopause? □ Yes □ No Please explain: _____________________________________
Have you ever had an abnormal pap smear? □ Yes □ No If circled yes, when was it? ____

FAMILY HISTORY: *Please indicate with a check (√) who in your family has had the following conditions. In the first column please indicate their living status. L = Living, D = Deceased, U = Unknown.*

	Living Status	Asthma	Diabetes	High Blood Pressure	Heart Disease	Stroke	Heart Attack	Cancer (Type)	Colon Polyps	Depression	Other
Mother											
Father											
Siblings											
Maternal Grandmother											
Maternal Grandfather											
Paternal Grandmother											
Paternal Grandfather											
Other Family Members Information: *(please write in)*											

SOCIAL HISTORY:

Exercise:
Do you exercise regularly? □ Yes □ No
Tobacco Use:
□ Current □ Never □ Former: quit on: ______
*If current # of packs/day ___ # of years ____
Other Tobacco: □ Pipe □ Cigar □ Snuff □ Chew
Are you interested in quitting? □ No □ Yes

Drug Use:
Do you use any recreational drugs?
□ Yes □ No
If yes please list ___________________
If you have used in the past, how long have you been drug free? ________
Have you ever used needles for IV drug use? □ Yes □ No

Alcohol Use
Do you drink alcohol? □ Yes □ No
If yes, # of drinks per week: __________
What type of alcohol: _______________
Is alcohol a concern for you or others who surround themselves around you?
□ Yes □ No

SAFETY

Do you wear a seatbelt regularly? □ Yes □ No
Do you wear a bike helmet regularly?
□ Yes □ No
Do you feel safe at home? □ Yes □ No
Do you feel safe in your current relationship?
□ Yes □ No

Have you ever been physically or sexually abused? □ Yes □ No
Do you have a gun in your home?
□ Yes □ No
Are you a member of a gang? □ Yes □ No
Other concerns: _____________________
____

SOCIOECONOMICS

Occupation:_________________________
Degree of education completed:_________
Marital Status: ________________________
Spouse/Partner's Name: _______________
Who lives at home with you? ___________

SEXUALITY

Are you sexually active? □ Yes □ No
Current sex partner(s) are: □ male □ female
If sexually active do you practice safe sex?
□ Yes □ No
Other Concerns: _____________________
____

Birth Control Method: _________________
Have you ever had a sexually transmitted disease? □ Yes □ No
If yes, please include: __________________
Are you interested in being screened for sexually transmitted diseases? □ Yes □ No

Other Services

Have you had a recent eye exam? □ Yes □ No
Have you had a recent dental exam?
□ Yes □ No
Do you see any other specialists? __________
____
____

EMOTIONS

In the past year, have you had 2 or more weeks during which you felt sad or depressed; or you lost all interest or pleasure in things that you usually cared about or enjoyed? □ Yes □ No
Have you had 2 or more years in your life when you felt depressed or sad most days, even if you felt okay sometimes? □ Yes □ No
Have you felt depressed or sad much of the time in the past year? □ Yes □ No
Do you ever feel like hurting yourself of others? □ Yes □ No

REVIEW OF SYSTEMS: *Please indicate with a check (√) any current problems you have below.*

Constitutional
Fevers/chills/sweats
Unexplained weight loss/gain
Fatigue/weakness
Excessive thirst or urination
Other: ______________________
____

Cardiovascular
Chest pain/discomfort
Leg pain with exercise
Heart murmur or heart problems
Palpitations
Other: ______________________
____

Chest
Breast lump/discharge
Other: ______________________
____

Ears/Nose/Throat/Mouth
Difficulty hearing/ringing in ears
Hay fever/allergies
Problems with teeth/gums
Difficulty swallowing
Difficulty with speech
Other: ______________________
____

Endocrine
Hypothyroid
Hyperthyroid
Abnormal hormone levels
Abnormal blood glucose levels
Other: ______________________
____

Eyes
Changes in vision
Farsighted
Nearsighted
Other: ______________________
____

Gastrointestinal
Abdominal pain
Blood in bowel movement
Nausea/vomiting/diarrhea
Other: ______________________
____

Genitourinary
Nighttime urination
Incontinence
Sexual function problems
Discharge from penis
Other: ______________________
____

Gynecological
Abnormal vaginal bleeding
Problems with conceiving
Problems with contraception
Vaginal discharge
Vaginal odor
Painful intercourse
Other: ______________________
____

Lymphatic/Blood
Unexplained lumps
Easy bruising/bleeding
Anemia
Other: ______________________
____

Musculo-skeletal
Muscle/joint pain
Arthritis
Other: ______________________
____

Neurological
Headaches
Dizziness/light-headedness
Numbness
Memory loss
Loss of coordination
Epilepsy or convulsive seizures
Other: ______________________
____

Psychiatric
Anxiety/stress
Problems with sleep
Depression
Suicidal ideations
Other: ______________________
____

Respiratory
Cough/wheeze
Difficulty breathing
Asthma
COPD
Sleep apnea
Other: ______________________
____

Skin
Rash or mole change(s)
Psoriasis
Eczema
Other: ______________________
____

Mclain Medical Associates, PC
(205) 991-8996

Cancellation, Late Arrival, and No-Show policy

Our providers attempt to provide timely and easily accessible high quality rheumatology care. There is a high demand for our services and we want to accommodate patients in an efficient and personalized manner. In order to accomplish this, we adhere to a schedule as closely as possible, recognizing there are times when changes are inevitable. The following appointment policies help us to minimize disruption in scheduling and help to reduce unnecessarily long wait times.

Cancellation of appointments:

If you cannot make your scheduled appointment time, please let us know by calling the office at (205) 991-8996 at least 24 hours in advance of your scheduled appointment to let us know you need to cancel or reschedule. We have an after-hours answering service that can take this information if you become aware of the need to reschedule outside of our regular office hours. This allows us time to offer our appointment time to another patient. Failure to provide 24 hours' notice of an appointment cancellation will result in a $25 charge to your account and you will be unable to reschedule until this fee is paid. Three late appointment cancellations will result in the inability to schedule with our providers.

Late arrivals:

If you arrive more than 15 minutes past your scheduled appointment time there is a possibility, we cannot accommodate you and you will be given the option to reschedule, wait for an opening in the provider's schedule if available, or be seen by another provider if they have an opening. If we can accommodate you the same day we will attempt to do so, but late arrivals do sometimes require rescheduling to a later date. If you arrive more than 30 minutes beyond your appointment without notifying us prior you will be subject to the $25 missed appointment fee. Three of these late arrivals of more than 30 minutes will result in the inability to schedule with our providers.

No-Show policy:

As stated above failure to provide 24 hours' notice of a missed appointment results in a $25 fee. Failure to provide any notice results in the fee and a record of a no-show appointment will be documented in your file. After three no-show appointments you will not longer be able to schedule an appointment with our providers.

We understand that emergencies do arise and we appreciate our patients abiding by these policies.

I have read the above and agree to abide by the cancellation, late arrival, and no-show policies.

Signature _______________________________________ Date _____________________________

McLain Medical Associates, P.C.

OFFICE POLICIES AGREEMENT

PATIENT COPY

Thank you for choosing McLain Medical Associates, P.C. for your medical care. We are committed to providing you with quality, personal health care. We appreciate your commitment to adhere to our Financial Policy Agreement.

OFFICE HOURS: our office is open Monday-Friday from 8:00 AM to 5:00 PM. We are closed in observance for major holidays.

COURTESY: We strive to provide the best medical care for our patients. While we make every effort to provide prompt on-time service, the healthcare needs of each individual patient are different and **DO NOT** necessarily lend themselves to an exact schedule. We therefore appreciate your understanding and patience. If you have any suggestion or complaint for our office, please let us know. However, angry or foul language directed to our staff, regardless of the issues involved, will absolutely not be tolerated and may be grounds for immediate dismissal from our practice.

____

FEES AND PAYMENTS: Except as indicated below or alternative arrangements have been made in advance, **payment is required at the time services are provided.** We accept cash, check, VISA AND MasterCard credit and debit cards.

____

- **INSURANCE:** All patients must complete and/or update our Patient Information Form at each office visit. You must furnish valid and up-to-date proof of insurance coverage and a copy of your driver's license. If you provide false or expired insurance information you will be responsible for the balance of the claim. Please notify us of any changes in insurance coverage prior to time of service. Insurance denials for termination of coverage will be automatically billed to you. Be familiar with your co-pay and be prepared to pay at each visit. It is your responsibility to know if the physicians are network providers prior to your office visit. You are responsible for any services not covered under your plan.

____

- **CO-PAYMENTS AND DEDUCTIBLES:** All co-payments, current balances, co-insurance and deductibles are **DUE and payable PRIOR to services being rendered and are required by your insurance to be paid at each visit.** Failure to pay your copay or deductible may result in your appointment being rescheduled. If not paid at time of service, a $5.00 administrative billing fee will be assessed to your account at

checkout. Our billing department will bill or credit your account accordingly when your insurance pays their portion.

____

- **CLAIM SUBMISSION:** Even though we will bill your insurance company if we are providers, we are not responsible to negotiate a settlement for a disputed claim. The agreement of the insurance carrier to pay for medical care is a contract between you and the carrier. Billing your insurance does not necessarily ensure payment by the insurance company nor does it release the responsible party from its financial obligation to our office for any unpaid balance. In case of an insurance partial payment, the balance, or allowable balance if we are under contract with the carrier, is due by you and we will send you a billing statement and you will be subject under our Patient Balance policy. If we are a provider, we will submit your insurance claims and assist you in any way reasonable to help get your claim paid. Your insurance company may need you to supply information directly to them. It is your responsibility to comply with their request in a timely manner.

____

- **PATIENT BALANCE POLICY:** After filing with insurance companies, you will be mailed a Patient Balance statement. Payment is due, in full, upon receipt of this statement. If you have any questions or dispute the balance, it is your responsibility to contact our billing office within 30 days. Past due accounts will be subject to a 15% per month or $5.00 per month minimum late fee charge and may be referred to a credit bureau and/or a collection agency. If you are not able to pay the balance in full, you must contact our billing office to discuss a payment schedule. Any late fees already incurred on past due balances will be included in any mutually agreed upon arrangements.

____

- **REFERRALS:** Unless discussed and evaluated in the office prior to the referral, all referrals require seeing the doctor to discuss the best treatment plan. If your managed care plan requires approval or authorization for referrals to a specialist, radiological imaging, medical facility care, etc., it is your responsibility to inform the office of this requirement prior to the referral. We require a 48-hour notice to facilitate a referral request and cannot issue retroactive referrals.

____

- **SELF-PAYMENT:** McLain Medical Associates recognizes that some of our patients may be without insurance coverage or may choose to receive care even when we are not "Participating Providers" with their managed care plan. We do not believe in, nor do we endorse charging a fee greater than the fees we have agreed to receive

from most managed care networks. Please let us know in advance if you are in this situation, so we may help determine the best way to handle your account.

____

OTHER SERVICES, CHARGES AND PATIENT RESPONSIBILITES: Insurance coverage generally does not include coverage for many administrative services, such as requests for information, prescription refills or after-hours medical consultation. The following services may have an administrative service charge that will be billed directly to you and are your responsibility for payment. Our practice is committed to providing the highest quality of service to our patients while keeping our charges for administrative services at or below the usual and customary charges of other medical practices. All such administrative fees must be paid to scheduling future appointments.

____

- **MISSED APPOINTMENTS:** It is your responsibility to remember your appointment. However, we do understand that there may be times when you might have to miss an appointment due to other obligations or emergencies. Broken appointments represent not only a cost to us, but also an inability to provide services to others who could have been seen in the time ser aside for you. We require **24-hour notice** of cancellation to avoid a **$25-$75 cancellation fee** (depending on the type of appointment.)

____

- **PRESCRIPTION REFILLS:** New prescriptions will not be issued without first seeing the physician. Prescriptions for acute care or chronic conditions are usually E-scripted with an appropriate number of refills to complete the course of treatment or to last until your next scheduled appointment. These do not require further approval for refills. Please make certain that you have enough prescription refills to last until your next appointment. Consult your pharmacist to see if you have a refill available. An administrative fee may be assessed if a refill is issued without the patient seeing a provider, a prescription is requested for mail order, additional "extra" prescriptions are needed, or a pharmacy (or insurance plan) change is requested. Requests for refills will be handled between 8:30 A.M. and 3:00 P.M., Monday through Friday. Any refill request after 3:00 P.M. will be handled on the next business day. **Please allow 48 hours for prescription refills.** Narcotic and antibiotic prescriptions will not be refilled after hours. Pain medications will not be adjusted over the phone. If there is a change in pain medication requirements, then an office appointment and evaluation must be made prior to any further refills or different medication being prescribed.

____

- **PRIOR AUTHRIZATIONS:** Prior Authorizations are time consuming and are a part of the contract that the patient has with their insurance carrier. We will honor prior authorization requests from the patient, but the patient will be responsible for

contacting their insurance company to have them forward the prior authorization form to our office. The patient will need to ask their insurance plan what "alternative medications" are covered by their plan. If the involvement is purely clerical activity, there will be an administrative fee charged directly to the patient, which is not billable to insurance. This fee will be payable at the time of the service and is due regardless of the outcome of the prior authorization request. There will be a minimum of a $15 fee for completion of any prior authorization form. Prior Authorizations requiring extensive administrative time will incur a higher fee of $35. Medication changes for the purpose of benefit coverage under your insurance plan will not be done over the phone. If a medication change is requested, the patient must be seen and evaluated by the physician.

____

- **FORM COMPLETION POLICY:** All forms requiring medical review and physician signature (including but not limited to school, FMLA, disability or other paperwork) may be subject to an administrative fee of $25. Administrative fees may be waived if the patient has a scheduled appointment in conjunction with the form completion. **Please allow 5-7 business days for completion.**

____

- **HEALTH CARE ADVICE:** With the advent of the internet and other sources of health information, we are often consulted for health care advice, frequently unrelated to the patient's current medical care or needs. Providing such information may require considerable thought and/or investigation on our part to coordinate with the patient's exact medical condition. Therefore, if such advice is unrelated to the patient's current medical condition, it may be subject to an administrative fee of $75 per quarter hour of investigation and response.

____

- **REQUEST FOR MEDICAL RECORDS:** In accordance with Alabama law and HIPPA, McLain Medical Associates requires written requests for the release of medical records. All requests for medical records must be properly and completely filled out and signed by the patient or legal guardian. Improperly filled out forms may delay your request. For continuity of care and as a courtesy to the patient, our office will forward records requested at no charge. Medical records released to the patient, some insurance companies, law firms or miscellaneous requests are subject to copying fees as specified by state law. Expedited copies will be charged an additional fee of $50.

____

- **RETURN CHECK POLICY:** A $45.00 service fee will be charged if a check is returned because of insufficient funds. We may also select to discharge you from

our practice should you fail to comply with our policies. Should you require a payment plan, our office manager will be glad to discuss your options with you.

____

I have acknowledged, read and understand McLain Medical Associates, P.C. Financial Policy Agreement. I agree to assign Insurance Benefits to MMA, PC whenever necessary. I authorize MMA, PC to release information to a credit bureau and/or collection agency. In the event of nonpayment or default, I am responsible for all costs and reasonable collection fees. Except for emergency care, patients may be denied services for their failure to agree to this Financial Policy Agreement.

Thank you for understanding of financial policy. Please let us know if you have any questions.

Printed Name: ____

Signature: ____

Date: ____

McLain Medical Associates, PC
2229 Cahaba Valley Drive
Birmingham, AL 35242
205-991-8996

LANGUAGE, RACE & ETHNICITY DETAILS

"Our practice is now collecting new demographic data to aid health agencies understand healthcare disparities, improve quality of care, and strengthen research and outreach. We appreciate your assistance in meeting these new national standards. McLain Medical Associates is dedicated to being your partner in improving patient care."

Race:
-- *American Indian or Alaska Native*
-- *Asian*
-- *Black or African American*
-- *Native Hawaiian or Other Pacific Islander*
-- *Caucasian/White*
-- *Multiracial*
-- *Refused/Declined*

Preferred Language:
--*English*
--*Spanish*
--*Other*

Ethnicity:
-- *Hispanic or Latino*
-- *Not Hispanic or Latino*
-- *Refused/Declined*