FCD Patient Data Form

Please complete all lines with an * including the "ethnic group" line, this is different from "race". We are now required to request this information from all patients.

Thank you for your cooperation.

***Patient:_____ *D.O. B.____/___/___ *Date___/___/___.**

***Social Security Number:___/___/___**

***Insurance Holder's Place of Employment:_____**

***Height:_____ *Weight: _____ *Gender: M____ F_____**

***Smoker:** Never____ Currently___ packs per day____ Former___ Quit approx. year_____

***Preferred Language:** English_____ Other_____

***Race:** Caucasian (white)___ American Indian___ Asian___ Alaskan Native____

African American (Black)___ Native Hawaiian/other Pacific Islander___

Other _____

***Ethnic Group**:Non-Hispanic / Non-Latin_____ Hispanic/Latin_____

***Preferred contact method :_____**

*** Is it OK to leave a detailed message?** Yes_____ No _____

***Preferred Pharmacy _____*Location: _____**

***Phone Number:** (if you know it) _____