

# FIRST COAST CARDIOVASCULAR INSTITUTE, P.A.

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Date: \_\_\_\_\_

Dear Patient,

We are required to request the following information. The Federal Administrative Reporting Agency requests that we provide this information for statistical purposes only. Your participation is optional. Please take a moment to complete the following questions.

*\*\*If you choose not to participate please initial here:* \_\_\_\_\_

*Thank you.*

## **Race:**

- American Indian / Alaskan Native       Asian       Black / African American  
 Native Hawaiian       Other Pacific Islander       Caucasian / White  
 More than one Race

## **Ethnicity:**

- Hispanic / Latino       Not Hispanic or Latino

## **Preferred Language:**

- English     American Sign Language     Arabic     Brazilian Portuguese  
 Chinese     Chinese (Cantonese)     Chinese (Mandarin)     Czech  
 Danish     Dutch     Farsi     Filipino     Finnish     French  
 French Canadian     German     Greek     Hindi     Hmong  
 Hungarian     Indian     Italian     Japanese     Khmer     Korean  
 Lao     Maori     Mien     Norwegian     Polish     Portuguese  
 Russian     Slovak     Somali     Spanish     Swahili     Swedish  
 Tagalog     Thai     Turkish     Tygrinian     Ukrainian     Vietnamese

Other \_\_\_\_\_

## **FCCI staff use only:**

Entered in Allscripts PM: Race \_\_\_\_\_ Ethnicity \_\_\_\_\_  
(Race and Ethnicity must go into PM - DO NOT enter Race, Ethnicity into EHR)

Entered in Allscripts EHR: Preferred language \_\_\_\_\_