

Legacy

PEDIATRICS

Patient Name: _____

Social Security #: _____

Date of Birth: _____

Race: American Indian/ Alaskan Native
 Asian
 Black/ African American
 Native Hawaiian/ Other

White
 Decline to Specify

Ethnicity:

Hispanic/ Latino
 Non-Hispanic / Latino
 Decline to Specify

Preferred Language:

English
 Spanish
 Other _____

Preferred Pharmacy:

Name: _____

Street Address: _____