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: _____