Centennial Medical Group – Patient Demographic Information

Last name _____ First Name _____ Middle Initial _____ Mr. Mrs. Miss Ms. Dr.

E-mail address (please write clearly) _____ Date of Birth _____

Driver's License Number _____ SSN _____

Marital information:

- o Divorced
- o Married
- o Single
- o Widowed

Preferred method of confidential communication

(Please choose only one)

- o Mail
- o E-mail
- o Home phone
- o Cell phone
- o Patient portal

Race (please check one)

- o Unknown / declined
- o American Indian or Alaska Native
- o Asian
- o African American
- o Native Hawaiian or Pacific Islander
- o Caucasian
- o White
- o Other _____

Ethnicity (please check one)

- o NOT Hispanic or Latino
- o Hispanic or Latino

Country of descent origin:

_____

Primary language spoken:

_____

Other languages spoken:

_____

Cell phone carrier (we need this information to send text messages for appointment reminders) _____

CELL phone number _____ HOME phone number _____

Signature _____ Date _____