CONFIDENTIAL PATIENT DEMOGRAPHICS

Patient Name: _____
(First) (Middle Initial) (Last)
Street Address: _____

City, State, ZIP: _____

Hm. Ph.: (___)_____ Wk. Ph.: (___)_____ Alt. Ph.: (___)_____

Preferred Method/Time of Contact: _____ Email: _____

Date of Birth: _____/_____/_____ Age: _____ □ Male □ Female
(MM / DD / YYYY)

Ethnicity: □ Hispanic □ Non-Hispanic
Race: □ Caucasian □ Afr. American
□ Native American □ Asian/Pacific-Islander □ Other: _____

Primary Care Physician Name: _____ PCP Phone#: ( ) _____
□ N/A

Name of Emergency Contact: _____ Relationship: _____

Hm. Ph.: ( )_____ Wk. Ph.: ( )_____ Alt. Ph.: ( )_____

Have you participated in any previous research studies? Yes □ No □ *If yes, when*? _____

How did you hear about Bandera Family Research? *Please specify*: _____

Would you like to refer a contact, friend or family member to BFHC Research? (*Optional*)

Name: _____ Telephone and/or email: _____

Patient Signature: _____ Date: _____/_____/_____

Reviewed By: _____ Date: _____/_____/_____