



## **DEMOGRAPHIC**

*Please specify the following*

Ethnicity:

Not Hispanic or Latino

Hispanic or Latino

Other

Preferred Language:

\_\_\_\_\_  
Race(s) [circle all that apply]:

American Indian/Alaska Native

Asian

Black/African American

Native Hawaiian/Other Pacific Islander

Other

White

## **NEXT OF KIN**

*Next of kin contact*

First name \_\_\_\_\_

Last name \_\_\_\_\_

Relation to patient \_\_\_\_\_

Address Line 1 \_\_\_\_\_

Address Line 2 \_\_\_\_\_

City \_\_\_\_\_

Country \_\_\_\_\_

State \_\_\_\_\_

Zip Code \_\_\_\_\_

Phone Number \_\_\_\_\_