ADDITIONAL INFORMATION Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(if no email, write “none”)

Preferred Pharmacy (Name & Location)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please choose one of the following Please choose one to describe

 to describe the patient’s race: the patient’s ethnicity:

\_\_\_Caucasian \_\_\_Latino/Hispanic

\_\_\_Black \_\_\_Haitian

\_\_\_Hispanic \_\_\_Other

\_\_\_Native American \_\_\_Not Latino/Hispanic

\_\_\_Pacific Islander \_\_\_Not applicable

\_\_\_Asian

\_\_\_More than One Race

\_\_\_Other Race

\_\_\_Don’t Know

ADDITIONAL INFORMATION Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(if no email, write “none”)

Preferred Pharmacy (Name & Location)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_More than One Race

\_\_\_Other Race

\_\_\_Don’t Know