Patient's information

Last name: ______________________________ First name: ___________________ MI: ___ SSN: ____ - ___ - ________

Sex: ☐ Male ☐ Female Date of birth: ____/____/_______ School/Dept: ______________________________

Address: ____ Home phone: (_____) ___________________________

____ Work phone: (_____) ___________________________

City: _____________________________ State: ____ Cell phone: (_____) ___________________________

Zip: __________ County: ______________________ Primary number: ☐ Home ☐ Work ☐ Cell

Interpreter requested: ☐ Yes ☐ No E-mail address: ___________________________

Preferred language: _______________________________ Are you of Latino or Hispanic origin: ☐ Yes ☐ No

Primary care doctor name: __________________________ Race (see other side): ______________________________

Country you were Born: _____________________

If employed, Department name: ____

Employment status: ☐ Full-time ☐ Part-time ☐ Self-employed ☐ Retired ☐ Other: ______________________

Student status: ☐ Not a student ☐ Full-time student ☐ Part-time student ☐ Other : ______________________

Emergency contact information

Last name: ______________________________ First name: ___________________ Relationship: __________________

Home phone: (_____) _____________ Work phone: (_____) _____________ Cell phone: (_____) _______________

This person lives at the same address: ☐ Yes ☐ No

Person responsible for bill (Guarantor)

Relationship of guarantor to patient: ☐ Self (If self, skip to insurance information) ☐ Other: __________________

Name: ____ Sex: ☐ Male ☐ Female Date of birth: ___ /___ /______

Address: ____ City: ___________________ State: ____ Zip: _________

Home phone: (_____) _____________ Work phone: (_____) _____________ Cell phone: (_____) _______________

Primary insurance ☐ **SELF- PAY (If self-pay, skip the insurance information below)**

Insurance company: ____ Plan name: ______________________________

Relationship of policy holder to patient: ☐ Self ☐ Mother ☐ Father ☐ Spouse ☐ Other: _________________

Covered through: ☐ Current employer ☐ COBRA ☐ Retirement ☐ Unknown ☐ Other: _________________

Plan type: ☐ HMO ☐ PPO ☐ POS ☐ EPO ☐ FSA/HSA/HRA ☐ Unknown ☐ Other: _________________

If the patient is the policy holder, skip the next line.

Policy holder name: ____ Policy holder date of birth: ___ /___ /______

Secondary insurance

Insurance company: ____ Plan name: ______________________________

Relationship of policy holder to patient: ☐ Self ☐ Mother ☐ Father ☐ Spouse ☐ Other: _________________

Covered through: ☐ Current employer ☐ COBRA ☐ Retirement ☐ Other

Plan type: ☐ HMO ☐ PPO ☐ POS ☐ EPO ☐ FSA/HSA/HRA ☐ Unknown ☐ Other: ____________________

Policy holder name: ____ Policy holder date of birth: ___ /___ /______

Why does University of Maryland ask about my race and ethnicity?

Evidence shows that there are still differences in the health care given to people in different racial, ethnic, and language groups. This leaves the most vulnerable groups of people at risk. This information can be used to measure delivery of healthcare services. The collection of accurate data gives us the groundwork to find differences and improve the quality of care. This information helps us to provide the best care by using interpreters, translating patient healthcare information, improving the rate of preventive services and providing cultural competency training for staff.

Your health care time will ask you the following questions:

Do you consider yourself of Latino or Hispanic origin?

- Hispanic or Latino
- Not Hispanic or Latino
- Unknown

What race should we record for you?

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- Two or More Races
- Unknown
- White or Caucasian

You may decline to answer these questions.