

# Coal Creek Family Medicine Questionnaire

First and Last Name: \_\_\_\_\_ Patient's Date of Birth: \_\_\_\_\_

Please answer the following:

1. Please select the following **Race** that you classify yourself as:

- Asian
- Black/African American
- Native American Indian
- Alaska Native
- Other Pacific Islander
- White/Caucasian
- Decline to Specify
- Hispanic or Latino
- Not Hispanic or Latino

2. What **Language** will you be using to communicate with our office and providers:

\_\_\_\_\_

3. Who do you designate as your **Primary Care Physician (PCP)**:

\_\_\_\_\_

4. Please provide us with your **Email** address so that we may contact you:

\_\_\_\_\_ @ \_\_\_\_\_

5. How were you referred to our Practice?

\_\_\_\_\_

6. Please list an **Emergency Contact**:

\_\_\_\_\_

Name

\_\_\_\_\_

Relationship

\_\_\_\_\_

Phone#

\_\_\_\_\_

Alternate Phone #