Coal Creek Family Medicine
Questionnaire

First and Last Name: _____ Patient's Date of Birth: _____

Please answer the following:

1. Please select the following **Race(s)** 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. Would you like to receive our Coal Creek Family Medicine Email Newsletter?

   Please Select ONE: YES _____ NO_____

6. How were you referred to our Practice?

   _____

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

   _____ _____
   Name Relationship

   _____ _____
   Phone# Alternate Phone #