



White Bird Medical Clinic

DEMOGRAPHICS QUESTIONNAIRE

NAME: _____ DATE OF BIRTH: _____ TODAY'S DATE: _____

SEX ASSIGNED AT BIRTH

- Male
- Female
- Intersex

RACE (choose all that apply)

- Asian
- Native Hawaiian
- Pacific Islander (Not Hawaiian)
- African American
- Native American/ Alaska Native
- White
- Prefer not to say

ETHNICITY

- Hispanic or Latino
- Not Hispanic or Latino
- Prefer not to say

VETERAN STATUS

- Yes, I am a veteran
- No, I am not a veteran

Emergency Contact

Name:	Phone:	Relationship:

GENDER IDENTITY

- Female
- Male
- Transgender male (FTM)
- Transgender female (MTF)
- Non-binary (for example genderqueer, genderfluid, agender, two-spirit)
- Don't know
- Prefer not to say

SEXUAL ORIENTATION

- Lesbian or Gay
- Straight
- Bisexual
- Something else
- Don't know
- Prefer not to say

DISABILITY STATUS

- Yes, I have a disability
- No, I do not have a disability

OFFICE USE ONLY

TYPT APPT: ACUTE ONLY WISH TO ESTABLISH CARE DEMOGRAPHIC ONLY
 RECEIVED APPT: Same Day <1 week (w/in 1 week) >1 week
 NOT SEEN: Referred to ER/ Urgent Care Referred to Clinic/ Specialty/ Resource Other
 SEEN BY: Staff Physician Volunteer Provider Nurse Visit