

# Meaningful Use



PLEASE LET US KNOW IF YOU HAVE HAD A CHANGE IN INSURANCE OR RECEIVED UPDATED INSURANCE CARDS!!

**Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Communication Preference:** (Circle) Phone Mail Email

**Email:** \_\_\_\_\_

- Race:**
- American Indian or Alaskan Native
  - Asian
  - Black or African American
  - Eskimo
  - Hispanic or Latino
  - Native Hawaiian or Pacific Islander
  - White or Caucasian
  - Other: \_\_\_\_\_

- Ethnicity:**
- Hispanic or Latino
  - Not Hispanic or Latino

**Primary Language:** Chinese English French German Italian  
Japanese Portuguese Russian Spanish Other \_\_\_\_\_

## Pharmacy Information

**Retail Pharmacy Name** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Address** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

**Mail Order Pharmacy** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Address** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

\_\_\_\_\_  
**Signature of Patient/Responsible Party** **Date**