



# UDS Demographics

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Please tell us about yourself or, if you are accompanying a patient, the patient who is being seen today. **As a Federally Qualified Health Center we are required to report the information request on this survey.** Your cooperation is greatly appreciated and your answers will be held in strictest confidence.

1. What is the patient's date of birth? (Month/day/year) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

2. What is the patient's gender? Female  Male

3. What is the patient's race? (Please check one)

Asian  American Indian or Alaska Native  Black or African American   
Native Hawaiian  Pacific Islander  White  More than one race

4. Is the patient Hispanic or Latino? Yes  No

5. Would it be useful for the patient to communicate in a language other than English? Yes  No

6. What is your patient's family size (please circle one) 1 2 3 4 5 6 7 8 9 10 Other \_\_\_\_\_

and income? Monthly \$ \_\_\_\_\_ or Annually \$ \_\_\_\_\_

7. How will this visit be paid? (check the single largest payment source)

Medicare

Medicaid

Other Public Insurance  \_\_\_\_\_ (please, specify)

Private Insurance  \_\_\_\_\_ (please, specify)

Self-Pay

8. Are you a United States Veteran? Yes  No