



**PALM BEACH  
SPORTSMEDICINE**  
AND ORTHOPAEDIC CENTER, P.A.  
PHYSICAL THERAPY

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PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

IN ORDER FOR OUR OFFICE TO MEET THE GOVERNMENT ELECTRONIC MEDICAL RECORDS GUIDELINES WE NEED YOU TO ANSWER THE FOLLOWING QUESTIONS:

PLEASE CHECK:

1. RACE:

\_\_\_\_\_ AMERICAN INDIAN OR ALASKAN NATIVE

\_\_\_\_\_ ASIAN

\_\_\_\_\_ BLACK

\_\_\_\_\_ CAUCASIAN

\_\_\_\_\_ PACIFIC ISLANDER

\_\_\_\_\_ OTHER

\_\_\_\_\_ DECLINED

2. ETHNICITY:

\_\_\_\_\_ HISPANIC

\_\_\_\_\_ NON HISPANIC

\_\_\_\_\_ DECLINED

3. PREFERRED LANGUAGE: \_\_\_\_\_