

**ETHNICITY & RACE FORM**

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



PATIENT'S NAME: \_\_\_\_\_  
 FIRST MIDDLE INITIAL LAST

BIRTH DATE: \_\_\_\_\_ MRN: \_\_\_\_\_

We are asking our patients to share their ethnicity and race. This will help us to know our patients better and improve health care for everyone. Personal information will remain private and confidential.

**Ethnicity:** Your ethnicity refers to your background heritage, culture, religion, ancestry or sometimes the country where you were born.

**Race:** Your race is the group(s) that you relate to as having similar features, traits or birthplace.

**What is your ETHNICITY?**

SELECT 1

<input type="checkbox"/> NOT HISPANIC OR LATINO OR SPANISH ORIGIN <input type="checkbox"/> HISPANIC OR LATINO OR SPANISH ORIGIN (If yes, please select up to 3 choices below) <hr/> <input type="checkbox"/> ANDALUSIAN <input type="checkbox"/> ARGENTINEAN <input type="checkbox"/> ASTURIAN <input type="checkbox"/> BELEARIC ISLANDER <input type="checkbox"/> BOLIVIAN <input type="checkbox"/> CANAL ZONE <input type="checkbox"/> CANARIAN <input type="checkbox"/> CASTILLIAN <input type="checkbox"/> CATALONIAN <input type="checkbox"/> CENTRAL AMERICAN <input type="checkbox"/> CENTRAL AMERICAN INDIAN	<input type="checkbox"/> CHICANO <input type="checkbox"/> CHILEAN <input type="checkbox"/> COLOMBIAN <input type="checkbox"/> COSTA RICAN <input type="checkbox"/> CRIOLLO <input type="checkbox"/> CUBAN <input type="checkbox"/> DOMINICAN <input type="checkbox"/> ECUADORIAN <input type="checkbox"/> GALLEGO <input type="checkbox"/> GUATEMALAN <input type="checkbox"/> HONDURAN <input type="checkbox"/> LA RAZA <input type="checkbox"/> LATIN AMERICAN <input type="checkbox"/> MEXICAN <input type="checkbox"/> MEXICAN AMERICAN <input type="checkbox"/> MEXICAN AMERICAN INDIAN <input type="checkbox"/> MEXICANO	<input type="checkbox"/> NICARAGUAN <input type="checkbox"/> PANAMANIAN <input type="checkbox"/> PARAGUAYAN <input type="checkbox"/> PERUVIAN <input type="checkbox"/> PUERTO RICAN <input type="checkbox"/> SALVADORAN <input type="checkbox"/> SOUTH AMERICAN <input type="checkbox"/> SOUTH AMERICAN INDIAN <input type="checkbox"/> SPANIARD <input type="checkbox"/> SPANISH BASQUE <input type="checkbox"/> URUGUAYAN <input type="checkbox"/> VALENCIAN <input type="checkbox"/> VENEZUELAN <hr/> <input type="checkbox"/> UNKNOWN <input type="checkbox"/> PATIENT DECLINED
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**What is your RACE? (You may select up to 4 choices):**

<input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE <input type="checkbox"/> ASIAN <input type="checkbox"/> ASIAN INDIAN <input type="checkbox"/> BANGLADESHI <input type="checkbox"/> BHUTANESE <input type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> BURMESE <input type="checkbox"/> CAMBODIAN <input type="checkbox"/> CAROLINIAN <input type="checkbox"/> CHAMORRO <input type="checkbox"/> CHINESE <input type="checkbox"/> CHUUKESE <input type="checkbox"/> FIJIAN <input type="checkbox"/> FILIPINO <input type="checkbox"/> GUAMANIAN <input type="checkbox"/> GUAMANIAN OR CHAMORRO <input type="checkbox"/> HMONG <input type="checkbox"/> INDONESIAN <input type="checkbox"/> IWO JIMAN <input type="checkbox"/> JAPANESE	<input type="checkbox"/> KIRIBATI <input type="checkbox"/> KOREAN <input type="checkbox"/> KOSRAEAN <input type="checkbox"/> LAOTIAN <input type="checkbox"/> MADAGASCAR <input type="checkbox"/> MALAYSIAN <input type="checkbox"/> MALDIVIAN <input type="checkbox"/> MARIANA ISLANDER <input type="checkbox"/> MARSHALLESE <input type="checkbox"/> MELANESIAN <input type="checkbox"/> MICRONESIAN <input type="checkbox"/> NATIVE HAWAIIAN <input type="checkbox"/> NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER <input type="checkbox"/> NEPALESE <input type="checkbox"/> NEW HEBRIDES <input type="checkbox"/> OKINAWAN <input type="checkbox"/> OTHER <input type="checkbox"/> OTHER PACIFIC ISLANDER <input type="checkbox"/> PAKISTANIAN	<input type="checkbox"/> PALAUAN <input type="checkbox"/> PAPUA NEW GUINEAN <input type="checkbox"/> POHNPEIAN <input type="checkbox"/> POLYNESIAN <input type="checkbox"/> SAIPANESE <input type="checkbox"/> SAMOAN <input type="checkbox"/> SINGAPOREAN <input type="checkbox"/> SOLOMON ISLANDER <input type="checkbox"/> SRI LANKAN <input type="checkbox"/> TAHITIAN <input type="checkbox"/> TAIWANESE <input type="checkbox"/> THAI <input type="checkbox"/> TOKELAUAN <input type="checkbox"/> TONGAN <input type="checkbox"/> VIETNAMESE <input type="checkbox"/> WHITE <input type="checkbox"/> YAPESE <hr/> <input type="checkbox"/> UNKNOWN <input type="checkbox"/> PATIENT DECLINED
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**Collecting Ethnicity and Race information helps us to know our patients better.**

Starting in December 2014, UPMC will ask you to share with us your ethnicity and race. This will help us to know our patients better and improve health care for everyone. Personal information will remain private and confidential.

**What is your Ethnicity?**

Your ethnicity refers to your background heritage, culture, religion, ancestry or sometimes the country where you were born.

For New York State reporting, we are collecting whether or not your ethnicity is Hispanic, Latino or of Spanish Origin. If your Ethnicity IS Hispanic, Latino or of Spanish Origin, you may then select up to 3 Hispanic, Latino or of Spanish Origin choices.

**What is your Race?**

Your race is the group(s) that you relate to as having similar features, traits or birthplace.

**By knowing you better, we can provide better care to our patients.**

Our goal is to meet the needs of all of our patients and understand our patients better. We can better meet our patient's needs if we know more about them.