

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

Appointment Time: \_\_\_\_\_

Clinician: \_\_\_\_\_

**The Centre for Behavioral Health**



New Patient Information

Page 1 of 7

**PATIENT INFORMATION**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex:  M  F  
Last First MI

Address: \_\_\_\_\_

City State Zip

Mailing address:  Check if same as above

Address \_\_\_\_\_

City State Zip

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_ SSN: \_\_\_\_\_

Marital Status:  Single  Life Partner  Married  Divorced  Separated  Widowed  Declined

Race:  American Indian or Alaska Native  Asian  
 Black or African American  White  
 Native Hawaiian or other Pacific Islander  Declined

Religion: \_\_\_\_\_  Declined

Ethnicity: Do you consider yourself to be Hispanic or Latino  Yes  No  Declined Other: \_\_\_\_\_

Preferred Language:  English  Other (please specify): \_\_\_\_\_

**NEXT OF KIN**  Check if ok to contact

Name: \_\_\_\_\_ Relation to patient: \_\_\_\_\_  
Last First

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation to patient: \_\_\_\_\_  
Last First

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**ALLERGIES**  No Known Drug Allergies

Medication: \_\_\_\_\_ Reaction: \_\_\_\_\_

Medication: \_\_\_\_\_ Reaction: \_\_\_\_\_

Other (latex, adhesive, food, environment): \_\_\_\_\_

**MEDICATIONS**  None

Please list any medications you are taking (including aspirin, vitamins, supplements or any other over the counter medication).

Name of Medication	dose	How often do you take	Reason for taking

PHARMACY	Address/Cross Streets	Phone Number	Preferred
Local: _____	_____	_____	<input type="checkbox"/>
Alternative: _____	_____	_____	<input type="checkbox"/>
Mail Order: _____	_____	_____	<input type="checkbox"/>

**PLEASE USE THIS SPACE FOR ANY ADDITIONAL INFORMATION**

\_\_\_\_\_

**Primary Insurance Information**

Insurance Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

Member ID/Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Copay: \_\_\_\_\_

Policy Holder:  Self (skip to next section)

Name: Last \_\_\_\_\_ First \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_ Sex:  M  F

Relation to Patient: \_\_\_\_\_

***\*If you have secondary insurance, please provide a copy of the card at check in.\****

**PARTY RESPONSIBLE FOR PAYMENT**  Check if same as patient

Name: \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ DOB: \_\_\_\_\_ mm/dd/yy

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

SSN: \_\_\_\_\_ Relation to patient: \_\_\_\_\_

**Employer:** \_\_\_\_\_ Employer Phone: \_\_\_\_\_ Occupation: \_\_\_\_\_

Status:  Part-time  Full-time  Self-Employed  Retired  Active Military  Disabled  Student  
 Unemployed  Unknown

**CARE TEAM**

Primary Care Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Therapist Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Phone Number: \_\_\_\_\_

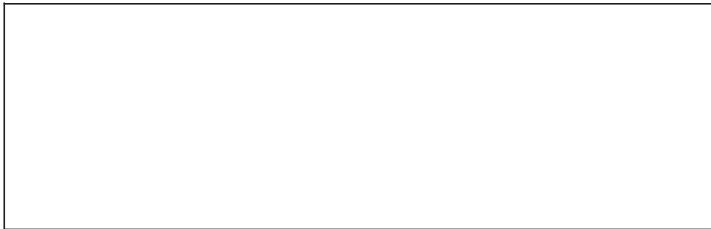
Psychiatrist Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Specialist Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Specialist Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**How did you hear about our practice?**

Referring Physician  Friend/Family: Name: \_\_\_\_\_  Event: Name: \_\_\_\_\_  
 Online/Practice Website  Insurance  Newspaper  Direct Mail  Television  Billboard



**AUTHORIZATION TO LEAVE TELEPHONE INFORMATION**

The Centre for Behavioral Health is committed to ensuring the privacy and confidentiality of your medical/personal information. We comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

To assist us in protecting your privacy, please complete the following information:

Number to best contact you: \_\_\_\_\_  Home  Cell  Work

May we leave a clinical message if no answer?  Yes  No

May we leave information with someone other than you regarding your medical care (medication changes, laboratory results, billing issues, appointments, etc.)? If so, please list the name(s) in the space(s) below.

Billing Issues:  Yes  No

Clinical Issues:  Yes  No

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relation to patient: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relation to patient: \_\_\_\_\_

Parent or Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Please Print

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

***I AM AWARE THAT THIS PERMISSION CAN BE REVOKED AT ANY TIME***

**Hospital Service Agreement**

CHADM-001 rev. 01/18

Page 1 of 2

EPIC # 201047 Hospital Service Agreement

**HOSPITAL SERVICE AGREEMENT – PATIENT-HOSPITAL CONTRACT**

1. **CONSENT FOR HEALTH CARE SERVICES.** I voluntarily consent to and authorize the rendering of health care services, including routine hospital services, diagnostic procedures, intravenous therapy, medications, injections, laboratory services, and other services or procedures, including the use or potential use of restraint, which my attending physician or others holding clinical privileges consider necessary in person or telehealth. I understand that health care services may be rendered by students, interns or residents under supervision. I further understand that the practice of medicine is not an exact science and I acknowledge that no promises or guarantees have been made to me regarding treatment or services rendered in this health care facility. I acknowledge Centura Health facilities and providers do not provide medical aid in dying medication or related services. I understand that my rights and responsibilities with regard to my care are described in more detail on the Patient Bill of Rights document.
2. **INDEPENDENT PRACTITIONERS.** I understand that many of the professionals who provide care to me in the hospital are not employees or agents of the Hospital. These professionals may include my own physician, other physicians requested by my physician to participate in my care as well as emergency department physicians, radiologists, pathologists and anesthesiologists. As a result, I understand that these professionals will bill me for charges that are separate from those of the Hospital. I understand that, in some cases these professionals may not be participating providers under my insurance plan. I understand it is my responsibility to verify whether professionals providing my care are participating providers under my insurance. I understand it is my responsibility for out of network costs or other costs because the professional does not have a contract with my insurance plan. I understand that by entering into this Patient-Hospital Contract, I agree and acknowledge that I have personal financial responsibility for any charges or costs not covered by my insurance, if I have any.
3. **MEDICARE and/or MEDICAID CERTIFICATION.** I certify that the information given by me in applying for payment under the Medicare and/or Medicaid programs is correct, and I authorize the release of all information needed to act on this request. I request that payment of authorized benefits be made to the Hospital on my behalf for the Hospital's and physicians charges for which the Hospital is authorized to bill in connection with these health care services.
4. **RETENTION OF SPECIMENS.** I authorize the Hospital to take, retain, preserve and use for scientific or teaching purposes, or dispose of at its convenience all specimens, tissues, parts or organs taken from my body during my hospitalization.
5. **FINANCIAL AGREEMENT.** I understand that there is no guarantee of reimbursement or payment from any insurance company or other payer. I understand this Agreement is a contract and that it obligates me to pay all charges for my treatment not paid by my insurer or any other payer source. I understand the Hospital has pre-determined the charges for certain procedures, supplies, and treatments, which these charges are listed in the Hospital's Chargemaster, and these prices are incorporated by reference into this Contract. I acknowledge it may not be possible to state in advance which specific supplies and services will be part of my treatment. I acknowledge I have the right to receive an estimate of the facility's average charge for treatment that are frequently performed on in-patient, outpatient, or surgical procedures. If I receive an estimate of charges, I acknowledge that the Hospital is acting in good faith by providing such an estimate. I acknowledge that any estimate is not binding and that the charges I am personally obligated to pay may be more than the estimated charge for my specific treatment. I acknowledge this Contract means I personally have full financial responsibility for, and agree to pay, all charges for the Hospital and of physicians rendering services not otherwise paid by my health insurance or other payer based upon the Hospital's pre-determined Chargemaster rates. Estimated patient responsibility is due at the time of service or following the medical screening exam. Any remaining charges are due and payable upon receipt of the bill. I acknowledge and understand that any refund that I may be owed will first be applied to any outstanding balance, and the remainder will be forwarded to the address on file with the Hospital.

If I do not have insurance or I cannot pay my bill, I may qualify for financial assistance. I understand that I may be required to submit documentation to determine my eligibility for financial assistance. I understand the hospital may request and use data from third parties such as credit reporting agencies in order to verify demographic data or evaluate financial options. If payment is not made within 180 days after receipt of the bill, a delinquent charge or interest at the maximum legal rate may be added. I agree to pay all legal expenses necessary for the collection of any debt or any action on this Contract. I hereby acknowledge and agree that the Hospital has not made any implied representations about the charges I am personally obligated to pay. I understand the charges I will be charged for my treatment are pre-determined rates based upon the Chargemaster in effect at the time of my treatment. I have agreed to pay the Hospital's Chargemaster rates for the treatment I receive.



Patient Label

Hospital Service Agreement

CHADM-001 rev. 01/18

EPIC # 201047 Hospital Service Agreement

6. COMMUNICATIONS CONSENT. By providing my cell or other phone number(s), I expressly consent to receive communications from the Hospital, its agents (including any collection agencies) or business associates at any numbers I provide or that are later acquired, to be used to contact me by live agent, voice mail, text message, using an auto dialer or other computer-assisted technology, pre-recorded message, or by any other form of electronic communication for any purpose, including scheduling, notifications, confirmations, reminders, instructions, accounting, billing, assignment of benefits, and/or collections. I understand that depending on my phone plan, I could be charged for these calls or text messages. I agree to provide new numbers if my numbers change. Providing these numbers is not a condition of receiving healthcare services. I consent to be contacted by regular mail or e-mail regarding any matter related to my account by the Hospital or any entity to which the Hospital assigns my account including any collection agency. I also consent to the use of any updated or additional contact information that I may provide by the Hospital or any entity to which the Hospital assigns to my account.

7. PREAUTHORIZATION REQUIREMENTS. I understand that it is my sole responsibility to obtain all pre-authorization and to comply with all requirements of any insurance or medical/hospital coverage plan upon which I am relying for coverage of the Hospital's and physicians' charges.

8. ASSIGNMENT FOR DIRECT PAYMENT. I authorize and direct that payment for any insurance or health care benefits otherwise payable to me for health care services or goods be made directly to the Hospital and my physicians, to include any hospital-based radiologists, pathologists, anesthesiologists and emergency department physicians. I understand that I am financially responsible to the Hospital or my physicians for charges, based upon Chargemaster rates, not covered or paid pursuant to this authorization.

9. PERSONAL VALUABLES. The Hospital maintains a safe for the safekeeping of any money or valuables. I understand that the Hospital does not assume responsibility for the loss, damage, or disposal of my personal property or money including jewelry, clothing, dentures, eyeglasses, contact lenses, hearing aids, prosthetic devices, or any other item unless such money or property is deposited with the Hospital. I take full responsibility for any money or property retained in my possession/room or brought to me while I am a patient at the Hospital.

10. \_\_\_\_\_ PATIENT ASSISTANCE PROGRAMS. In some cases, Hospital may be able to obtain reimbursement for the cost of some of my medications and/or medical devices from the companies that manufacture them. If this occurs, that portion of the cost that is paid will be removed from my bill for that hospital stay. By signing this form, I give Hospital, or an agent acting on Hospital's behalf, permission to: (1) sign the Patient Assistance Program applications on my behalf, (2) release any personal, medical, and/or financial information required by the Patient Assistance Programs in order to apply for free drug or device, and (3) receive payment on my behalf. Initial Here if Declined

11. \_\_\_\_\_ ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES. I acknowledge that Centura Health has offered me a copy of its Notice of Privacy Practices. I understand that the Notice of Privacy Practices is also electronically available on Centura Health's web-site. I understand this acknowledgement in no way affects the care I receive at the Hospital. (Initials)

I ACKNOWLEDGE I HAVE READ THIS FORM AND UNDERSTAND ITS CONTENTS AND HAVE RECEIVED A COPY HEREOF. I FURTHER ACKNOWLEDGE THAT I AM THE PATIENT, OR PERSON DULY AUTHORIZED EITHER BY THE PATIENT OR OTHERWISE, TO SIGN THIS AGREEMENT, CONSENT TO AND ACCEPT ITS TERMS.

\_\_\_\_\_  
SIGNATURE OF PATIENT OR LEGALLY RESPONSIBLE PERSON NAME DATE TIME

\_\_\_\_\_  
PRINTED NAME OF PATIENT OR LEGALLY RESPONSIBLE PERSON NAME

\_\_\_\_\_  
RELATIONSHIP / REASON WHY PATIENT IS UNABLE TO SIGN

\_\_\_\_\_  
ADDRESS OF PATIENT

## PATIENT BILL OF RIGHTS

### Patient Rights:

Centura Health Hospitals support the rights of all patients across the lifespan including geriatric, adult, adolescent, pediatric, infant and neonatal populations. These rights may be exercised through the patient individually or through their authorized surrogate decision maker.

You have the right to . . .

1. Be informed of your patient rights in advance of receiving or discontinuing care when possible.
  2. Receive care, treatment and visitation regardless of disability, national origin, culture, age, color, race, religion, gender identity, sexual orientation. No one is denied examination or treatment of an emergency medical condition because of their source of payment.
  3. Give informed consent for all treatment, procedures, and/or production of recordings, films or other images when used for other than identification, diagnosis or treatment.
  4. Be informed of your health status/prognosis, including unanticipated outcomes of care and the treatment and services related to serious preventable adverse events.
  5. Participate in all areas of your care plan, treatment, care decisions, and discharge plan.
  6. Receive appropriate assessment and prompt management of your pain.
  7. Be treated with respect and dignity.
  8. Experience personal privacy, comfort and security to the extent possible during your stay.
  9. Be free from restraints or seclusion imposed as a means of coercion, discipline, convenience or retaliation by staff.
  10. Experience confidentiality of all communication and clinical records related to your care. You will receive a copy of our Notice of Privacy Practices to inform you how your personal medical information can be used and disclosed and your rights related to your medical information.
  11. Have access to telephone calls, mail, and other communication devices. Any restrictions to access will be discussed with you, and you will be involved in the decision when possible or appropriate.
  12. Choose a "visitor" who may visit you, including but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend, and you have the right to withdraw or deny such choice at any time. You also have the right to select an identified "support person" who can make visitation decisions should you become incapacitated.
  13. If hospitalized, have the right to designate at least one post-discharge caregiver who will assist you with basic tasks following your discharge and, along with you or your authorized surrogate decision maker, provide consultation on your discharge plan. Designating a post-discharge caregiver does not mean the person you have designated is obligated to care for you.
  14. Be communicated with in a manner you can understand which is tailored your age, language, understanding and ability including access to interpreter services and communication aides, at no cost.
  15. Have access to pastoral/spiritual care.
  16. Receive care in a safe setting.
  17. Be free from all forms of abuse, neglect, mistreatment, or exploitation.
  15. Have access to pastoral/spiritual care.
  16. Receive care in a safe setting.
  17. Be free from all forms of abuse, neglect, mistreatment, or exploitation.
  18. Have access to protective services (e.g., guardianship, advocacy services, and child/adult protective services).
  19. Request medically necessary and appropriate care and treatment.
  20. Refuse any drug, test, procedure, or treatment and be informed of the medical consequences of such a decision.
  21. Consent to or refuse to participate in teaching programs, research, experimental programs, and/or clinical trials.
  22. Receive information about Advance Directives. Set up or provide Advance Directives and have them followed. Designate an authorized surrogate decision-maker as permitted by law and as needed.
  23. Participate in decision-making regarding ethical issues, personal values or beliefs.
  24. If hospitalized, have a family member or representative of your choice and your physician promptly notified of your admission to the hospital, upon request.
  25. Know the names, professional status and experience of your caregivers.
  26. Have access to your medical records within a reasonable timeframe.
  27. Be examined, treated, and if necessary, transferred to another facility if you have an emergency medical condition or are in labor, regardless of your ability to pay.
  28. Request and receive, prior to the initiation of non-emergent care or treatment, the charges (or estimate of charges) for routine, usual, and customary services and any co-payment, deductible, or non-covered charges, as well as the facility's general billing procedures including receipt and explanation of an itemized bill. This right is honored regardless of the source(s) of payment.
  29. Be informed of the hospital's complaint and grievance procedure and whom to contact to file a concern, complaint or grievance.  
Note: If you have financial issues or questions, please contact Centura Consumer Operations at (303) 486-5400.  
Toll free: 800-953-0104
- a. Our priority is for you to have a positive patient experience. If your concerns are not being resolved with your immediate care giver or the department manager or administrative staff, please call the Patient Care Representative/Advocate or access the hospital operator by dialing "0".

**PATIENT BILL OF RIGHTS  
CHADM-019 rev. 02/19****Epic # 201048 – Hospital Bill of Rights**

b. You may also contact The Health Facilities Division of the Colorado Department of Public Health and Environment or the Kansas Department of Health and Environment and the Office of Civil Rights directly regardless of whether you first used the hospital's complaint and grievance process.

The Colorado Department of Public Health and Environment  
4300 Cherry Creek Drive South  
Denver, CO 80222-1530  
Telephone: (303) 692-2827

The Kansas Department of Health and Environment  
1000 SW Jackson  
Topeka, Kansas 66612  
Telephone: (785) 296-1500

The Office for Civil Rights  
Department of Health and Human Services  
999 18th Street South Terrace, Suite 417  
Denver, Colorado 80202  
Telephone: 303-844-2024  
TDD 303-844-3439  
Fax: 303-844-2025

c. If you received care in a hospital, emergency department, home care or hospice and if after speaking with one of their representatives your complaint remains unresolved, you may contact The Joint Commission By mail to: Office of Quality and Patient Safety, The Joint Commission, One Renaissance Boulevard, Oakbrook Terrace, IL 60181; Online to: [www.jointcommission.org](http://www.jointcommission.org) using the "Report a Patient Safety Event" link in the "Action Center" on the home page of the website' By fax: to 630-792-5636

d. You also have the right to file a complaint with the appropriate oversight boards including the Colorado Board of Medical Examiners, the Colorado Dental and Podiatry Boards and the Colorado Department of Regulatory Agencies. For Kansas hospitals, this includes the Kansas State Board of Healing Arts, the Kansas Board of Nursing and the Kansas office of Health Occupations Credentialing. Contact information will be provided by a hospital representative upon request.

e. If you received care in one of our accredited mammography programs, and had a serious grievance\* that you feel was not adequately addressed by the facility, you may fax, e-mail, or mail to: Director, Breast Imaging Accreditation Programs American College of Radiology 1891 Preston White Drive Reston, VA 20191-4397  
\*A serious grievance is defined by the FDA as "a report of a serious adverse event, which means an event that significantly compromises clinical outcomes or one for which a facility fails to take appropriate corrective action in a timely manner."

**Patient Responsibilities:****You have the responsibility to . . .**

1. Ask questions and promptly voice concerns.
2. Give full and accurate information as it relates to your health, including prescription and non-prescription medications.
3. Report changes in your condition or symptoms, including pain, and request assistance of a member of the health care team.
4. Educate yourself. Learn about the medical tests that are being performed and understand your treatment plan.
5. Follow your recommended treatment plan.
6. Be considerate of other patients and staff.
7. Secure your valuables.
8. Follow facility rules and regulations.
9. Respect property that belongs to the facility or others
10. Understand and honor financial obligations related to your care, including understanding your own insurance coverage.

\_\_\_\_\_  
Initials I acknowledge that Centura Health has offered me a copy of its Non-Discrimination Statement. I understand that the Statement is also available to me as a handout if I choose, and is also electronically available on Centura Health's website.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_



Patient Label

We want you to know that providing you with the very best care is our highest consideration. To do that, it will help us to know a little bit about you.

While most diseases cross all ethnic/racial and gender boundaries, there are certain disease processes that are more likely to occur in a certain race or gender. In fact, some people may have different symptoms, or respond differently to treatments, because of these factors.

For that reason, we would like for you to share some information with us about your race/ethnicity. Sharing this information is entirely optional, but we believe it will assist our physicians and other caregivers in serving you best. It will not be used as a basis to deny or otherwise restrict the health care services you receive. Please consider the information below. Thank you.

Ethnicity

Do you consider yourself to be Hispanic or Latino according to the definition below? (Choose only one)

- Yes, I am Hispanic or Latino—A person of Mexican, Puerto Rican, Cuban, Central American, South American, or other Spanish culture or origin, regardless of race
Cuban Mexican, Mexican American, Chicano/a
Other Hispanic, Latino/a, or Spanish Origin Puerto Rican
No, I am not Hispanic or Latino
I decline to answer

Race

What race do you consider yourself to be?

- American Indian or Alaska Native—A person having origins in any of the original peoples of North, Central, or South America, and who maintains tribal affiliation or community attachment
Asian—A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam
Asian Chinese Japanese Vietnamese
Asian Indian Filipino Korean
Black or African American—A person having origins in any of the black racial groups of Africa
Native Hawaiian or other Pacific Islander—A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands
Guamanian or Chamorro Native Hawaiian Other Pacific Islander Samoan
White—A person having origins in any of the original peoples of Europe, the Middle East, or North Africa
I decline to answer

Refusal

I do not wish to provide some or all of the above information.

More than one race?

Yes



**Clasificación de la raza y la etnia**CHADM-012SP rev. 08/17 Página 1 de 1  
201049

Queremos que sepa que brindarle la mejor atención es nuestro principal interés. Para lograrlo, nos ayudará saber un poco más sobre usted.

A pesar de que la mayoría de las enfermedades atraviesan todos los límites étnicos/raciales y de sexo, hay ciertos procesos patológicos que tienen una mayor probabilidad de ocurrir en ciertas razas o en cierto sexo. En efecto, algunas personas pueden tener diferentes síntomas o responder de manera diferente a los tratamientos debido a estos factores.

Por ese motivo, nos gustaría que nos brinde cierta información sobre su raza/etnia. Compartir esta información es completamente optativo; no obstante, consideramos que ayudará a nuestros médicos y a otros prestadores de atención para que lo puedan atender mejor. No se usará como base para denegarle ni de otro modo restringir los servicios de atención médica que usted reciba. Le pedimos que considere la información que sigue. Muchas gracias.

**Etnia**

¿Se considera hispano o latino según la definición que sigue? (Elija solo una opción)

- Sí, soy hispano o latino**—Una persona de origen mexicano, puertorriqueño, cubano, centroamericano, sudamericano o de otra cultura u origen español, independientemente de la raza
- Cubano     Mexicano, mexicano estadounidense, chicano
- Otro origen hispano, latino o español     Puertorriqueño
- No, no soy hispano o latino**
- Me niego a contestar**

**Raza**

¿A qué raza considera usted que pertenece?

- Pueblo originario estadounidense o pueblo originario de Alaska**—Una persona con orígenes en cualquiera de los pueblos originarios de Norteamérica, Centroamérica y Sudamérica que conserva su afiliación tribal o los vínculos con la comunidad
- Asiática**—Una persona con orígenes en cualquiera de los pueblos originarios del Lejano Oriente, el sudeste asiático o el subcontinente indio, incluidos, por ejemplo, Camboya, China, India, Japón, Corea, Malasia, Pakistán, las Islas Filipinas, Tailandia y Vietnam
- Asiático     Chino     Japonés     Vietnamita
- Pueblo originario de Asia     Filipino     Coreano
- Negra o afroamericana**—Una persona con orígenes en cualquiera de los grupos de raza negra de África
- Pueblo originario de Hawái o de otra isla del Pacífico**—Una persona con orígenes en cualquiera de los pueblos originarios de Hawái, Guam, Samoa u otra isla del Pacífico
- Guamaniano o chamorro     Pueblo originario de Hawái     Otra isla del Pacífico     Samoano
- Blanca**—Una persona con orígenes en cualquiera de los pueblos originarios de Europa, el Medio Oriente o el norte de África
- Me niego a contestar**

**Negativa**

- No deseo proporcionar una parte o toda la información que antecede.**

**Más de una raza**

- Sí**