



Tower Orthopaedics and Sports Medicine and Tower Orthopaedics Neurosurgical Spine Institute

Today's Date: _____

- Dr. Bakshian Dr. Ganjianpour
 Dr. Patel

As part of the Patient Protection and Affordable Care Act it is required for all medical practices to update the following information for every patient.

Como parte de *Patient Protection and Affordanle Care Act* se les require a todas las clínicas médicas que actualicen la siguiente información sobre cada paciente.

Your Name (su nombre): _____ Date of Birth (fecha de nacimiento): _____

Race (raza):

- | | |
|--|---|
| <input type="checkbox"/> Alaskan Native | <input type="checkbox"/> Multi-racial |
| <input type="checkbox"/> American Indian | <input type="checkbox"/> Native American |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Other Race |
| <input type="checkbox"/> African American | <input type="checkbox"/> Pacific Islander |
| <input type="checkbox"/> Caucasian / White | <input type="checkbox"/> Unknown |

Language (idioma):

- | | | | |
|-----------------------------------|----------------------------------|-------------------------------------|----------------------------------|
| <input type="checkbox"/> Arabic | <input type="checkbox"/> French | <input type="checkbox"/> Japanese | <input type="checkbox"/> Russian |
| <input type="checkbox"/> Armenian | <input type="checkbox"/> German | <input type="checkbox"/> Korean | <input type="checkbox"/> Spanish |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Hebrew | <input type="checkbox"/> Mandarin | <input type="checkbox"/> Other |
| <input type="checkbox"/> English | <input type="checkbox"/> Hindi | <input type="checkbox"/> Polish | |
| <input type="checkbox"/> Farsi | <input type="checkbox"/> Italian | <input type="checkbox"/> Portuguese | |

Ethnicity (origen étnico):

- Hispanic or Latino Not Hispanic or Latino Unknown

Preferred Method of Contact (choose ONLY one box):

(Metodo Preferido para contactarlo – elegir un solo cuadro)

Phone (teléfono): () - _____

- Home (de casa) Day (día) Alternate (suplente) Cell (celular)

Email (correo electrónico): _____

Mail (correo):

Street Address (Dirección): _____ City/State/Zip: _____

Preferred Pharmacy (Farmacia de Preferencia): _____

Street Address (Dirección): _____ City/State/Zip: _____

Phone(teléfono): () - _____ Fax: () - _____

Tobacco Use (Consumo de tabacco):

- Current (presente) Former(ex consumidor) Never(nunca) Not Reported (no reportados)

Type (tipo): Cigarettes Cigars Chewing Pipe Smokeless Snuff

Smoking Status (estatus de fumador):

- Current every day smoker (cada día consume tabaco) Current some day smoker (algunos días consume Tabaco) Never (Nunca e consumido tabaco)