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## Ethnicity and Race Specification Form

This form needs to be completed for all members joining Placer Private Physicians (we are required by the government to collect this information for all our patients)

Primary Member:

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

Ethnicity (circle one):    Hispanic or Latino    Non Hispanic or Latino    Unknown    Decline to Specify

Race (circle one):    American Indian or Alaskan Indian    Asian    African American  
Hawaiian or Pacific Islander    White    Other  
Decline to Specify

Other Family Members (only designate if they are joining the practice):

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

Ethnicity: \_\_\_\_\_ Race: \_\_\_\_\_

(please write in appropriate category or designate "same as above")

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

Ethnicity: \_\_\_\_\_ Race: \_\_\_\_\_

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

Ethnicity: \_\_\_\_\_ Race: \_\_\_\_\_

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

Ethnicity: \_\_\_\_\_ Race: \_\_\_\_\_