

ROBERT J. KRAUT, M.D.

FLORIDA RETINA & VITREOUS CENTER, P.A.

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Patient Name: \_\_\_\_\_ D.O.B. : \_\_\_\_\_

The federal government requires us to ask the following as part of the American Recovery and Reinvestment Act.

Race: Please circle one

American Indian or Alaskan Native Alone	Black or African American	Native Hawaiian or Pacific Islander
Asian	White	Hispanic or Latino (All races)
Multi Racial	Other	Unknown or Decline to Provide

Ethnicity: Please circle one

Hispanic or Latino	Non-Hispanic or Latino	Unknown or Decline to provider
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Language preference: Please circle one

Arabic	Bulgarian	Central Khmer	Chinese
English	French	German	Haitian: Haitian Creole
Hebrew	Hindi	Italian	Japanese
Korean	Polish	Portuguese	Russian
Somali	Spanish; Castilian	Swahili	Thai
Urdu	Vietnamese		

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_