

**BERKSHIRE HEALTH SYSTEMS
DEMOGRAPHIC PROFILE AND PRIVACY PRACTICES**

PATIENT NAME _____ PATIENT NUMBER _____

(1) FEDERAL AND STATE LAW REQUIRES THAT WE COLLECT THIS DEMOGRAPHIC INFORMATION AND REPORT IT IN TABULATED FORM, WITHOUT ANY PATIENT IDENTIFYING INFORMATION:

LANGUAGE (Primary Spoken at Home)

- Arabic Japanese
 Cambodian Russian
 Chinese Sign Language
 English Spanish
 French Vietnamese
 German Other
 Italian Need Interpreter? _____

RACE (May indicate up to 3)

- American Indian/Alaskan Native
 Asian
 Black/African American
 Caucasian/White
 Hispanic/Latino/Spanish
 Native Hawaiian or Pacific Islander
 Other

ETHNICITY (May indicate up to 3)

- | | | |
|---|---|---|
| <input type="checkbox"/> African | <input type="checkbox"/> Chinese | <input type="checkbox"/> Korean |
| <input type="checkbox"/> African American | <input type="checkbox"/> Columbian | <input type="checkbox"/> Laotian |
| <input type="checkbox"/> American | <input type="checkbox"/> Cuban | <input type="checkbox"/> Mexican/Mexican American/Chicano |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Dominican | <input type="checkbox"/> Middle Eastern |
| <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Eastern European | <input type="checkbox"/> Portuguese |
| <input type="checkbox"/> Brazilian | <input type="checkbox"/> European | <input type="checkbox"/> Puerto Rican |
| <input type="checkbox"/> Cambodian | <input type="checkbox"/> Filipino | <input type="checkbox"/> Russian |
| <input type="checkbox"/> Cape Verdean | <input type="checkbox"/> Guatemalan | <input type="checkbox"/> Salvadoran |
| <input type="checkbox"/> Caribbean Island | <input type="checkbox"/> Haitian | <input type="checkbox"/> South American (not specified) |
| <input type="checkbox"/> Central American (not specified) | <input type="checkbox"/> Honduran | <input type="checkbox"/> Vietnamese |
| | <input type="checkbox"/> Japanese | <input type="checkbox"/> Other |

(2) AT BERKSHIRE HEALTH SYSTEMS, WE ARE COMMITTED TO THE HOLISTIC CARE OF PATIENTS, PART OF WHICH IS SPIRITUAL CARE. PLEASE INDICATE YOUR PREFERENCES:

RELIGION

- | | | |
|---|---|---|
| <input type="checkbox"/> American Methodist/Episcopal | <input type="checkbox"/> Episcopal | <input type="checkbox"/> Orthodox |
| <input type="checkbox"/> Assembly of God | <input type="checkbox"/> Hindu | <input type="checkbox"/> Other Religion |
| <input type="checkbox"/> Bahai' | <input type="checkbox"/> Jehovah Witness | <input type="checkbox"/> Pentacostal |
| <input type="checkbox"/> Buddhist | <input type="checkbox"/> Jewish | <input type="checkbox"/> Protestant |
| <input type="checkbox"/> Baptist | <input type="checkbox"/> Lutheran | <input type="checkbox"/> Quaker |
| <input type="checkbox"/> Catholic | <input type="checkbox"/> Methodist | <input type="checkbox"/> Salvation Army |
| <input type="checkbox"/> Christian (Non-Specific) | <input type="checkbox"/> Mormon | <input type="checkbox"/> Seventh Day Adventist |
| <input type="checkbox"/> Christian Science | <input type="checkbox"/> Muslim | <input type="checkbox"/> Unitarian/Universalist |
| <input type="checkbox"/> Congregational | <input type="checkbox"/> No Religion/Preference | <input type="checkbox"/> Unknown |

PARISH/CHURCH/TEMPLE/PLACE OF WORSHIP _____
(include name,city,and state)

(3) FEDERAL LAW REQUIRES THAT WE PROVIDE YOU WITH A COPY OF OUR NOTICE OF PRIVACY PRACTICES AND OBTAIN AN ACKNOWLEDGEMENT:

PRIVACY PRACTICES

My signature below indicates that I have been provided with a copy of the Notice of Privacy Practices.

DATE _____ SIGNATURE _____

If signed by Legal Representative, relationship to: _____

If unable to obtain signature, reason: _____