



Required Contact Information

PLEASE PRINT CLEARLY

Complete all fields of the following demographic data sheet and return via email or mail to:

Lorena Wilson, C.R.N.P.
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National Human Genome Research Institute
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Bethesda, MD, USA 20892-1375
Office 301-594-2500 Fax 301-480-3054
Email: lorena.wilson@nih.gov

Patient/volunteer Name: Last name: _____ First name: _____ Middle name: _____

Date of Birth: Month _____ Day _____ Year _____

Sex: Male _____ Female _____

Phone Number:

Email Address:

Home Mailing Address: (PO Box is not acceptable)

Ethnicity (please choose one):	Hispanic or Latino	Not Hispanic or Latino
Race (please choose one):	American Indian / Alaska Native Black/African American Multiple Races White	Asian Hawaiian/Pacific Island Unknown

Primary Language Spoken: Can you speak English fluently? ____ yes ____ no
 Can you read English fluently? ____ yes ____ no

If the patient is a minor, what is the primary language of the parents?
 Are the parents able to understand and speak English fluently?
 Are the parents able to read English fluently?

Referring physician: (Please include first and last name, specialty, address, phone, and fax number where you'll like to receive a copy of the report.)

Additional physician to receive reports*:** (Please include first and last name, specialty, address and phone number.)

Please check this box if you would like to receive a copy of the genetic report sent to your physician.