Keith A. Jackson, MD
DEMOGRAPHIC SHEET

PLEASE REVIEW AND FILL-IN ANY BLANKS THAT APPLY:

<table>
<tr><td>Last Name,</td><td>First Name</td><td>MI</td><td>Birth Date</td><td>Today's Date</td></tr>
<tr><td colspan="2">Address</td><td>City</td><td>State</td><td>Zip Code</td></tr>
<tr><td>Home Phone</td><td>Work Phone</td><td>Cell Phone</td><td>Gender</td><td>Patient Acct #</td></tr>
<tr><td>Language Pref.
Please select one:
□ English □ Italian
□ Spanish □ Japanese
□ French □ Korean
□ Arabic □ Mandarin
□ Chinese □ Persian
□ German □ Other
□ Greek</td><td colspan="2">Ethnicity. please select one
Hispanic or Latino- A person of Cuban, Mexican, Puerto Rican, South or Central America, or other Spanish culture or origin regardless of race. Please select:
□ Hispanic or Latino
□ Non-Hispanic or Latino
□ Decline to answer
□ Unknown</td><td colspan="2">Race. please select one
Race-Please select one race that closely identifies you:
□ Asian
□ American Indian or Alaskan Native
□ Native Hawaiian or Other Pacific Islander
□ Black or African American
□ White
□ Decline
□ Unknown</td></tr>
<tr><td>Employer's Name</td><td colspan="2">Employer's Address</td><td colspan="2">Referring Physician</td></tr>
<tr><td>Emergency Contact</td><td>Home Phone</td><td colspan="2">Work Phone</td><td>Relationship to Patient</td></tr>
</table>

PRIMARY INSURANCE SECONDARY INSURANCE

<table>
<tr><td colspan="2">Insurance Name</td><td colspan="2">Insurance Name</td></tr>
<tr><td colspan="2">Subscribers Name</td><td colspan="2">Subscribers Name</td></tr>
<tr><td>Subscribers ID</td><td>Group No.</td><td>Subscribers ID</td><td>Group No.</td></tr>
<tr><td>Subscribers Birth Date</td><td>Effective Date</td><td>Subscribers Birth Date</td><td>Effective Date</td></tr>
</table>

I authorize payment of my medical benefits be made directly to my physician for services rendered. I authorize the release of my medical records to my insurance company, medical facility or provider to facilitate my care. I consent to any medical treatment/physical exam required by myself or the minor above for who I am responsible for. I understand that I am financially responsible for any charges not covered by my insurance including, deductibles, co-pays and co-insurance.

_____ _____

SIGNED (Insured or Authorized) ***DATE***