Eye Surgery Center of East Tennessee
1124 E. Weisgarber Road, Suite 110
Knoxville, TN 37909
865-588-1037

LABEL

DIAGNOSTIC SUMMARY/ETHNICITY

Patient Name: _____ MRN: _____

Known Significant Medical Diagnoses and Conditions (Past and Current)	Date of Onset	(Date Recorded)

Known Surgeries/Invasive Procedures	Facility where Performed	Date	(Date Recorded)

As required by the Department of Health, The State of Tennessee mandates us to ask you the following questions:

RACE: **___White/Caucasian ___Black/African American ___Native American Indian/Alaskan Native**

___Asian/Pacific Islander ___Other Race (other than 1-4) ___Unknown Race ___Decline to Specify

LANGUAGE BARRIER: **___NONE ___YES-Other than English ___YES-Sign Language**

ETHNICITY: **___Hispanic Origin ___Non-Hispanic Origin ___ Hispanic Origin Unknown ___ Decline to Specify**

PLEASE COMPLETE AND BRING THE DAY OF SURGERY