Facility ID Number	(auto filled)
Case Registration Date	____/____/_____ (mm/dd/yyyy)
1. Patient Information	
Patient ID	(auto filled)
*Social Security Number or Other ID	SSN: _____ - _____- _____ Or Other ID: _____ Description:_____ (e.g. SIN)
*First Name	_____
Middle Name	_____
*Last Name	_____
*Old Medicare Beneficiary ID *(prior to April 2018)*	_____
*New Medicare Beneficiary ID *(April 2018 or later)*	_____
*Date of Birth	____/____/_____ (mm/dd/yyyy)
*Patient Sex	Select one: O Male O Female O Other O Unknown
Race	Select one: O American Indian or Alaska Native O Asian O Black or African American O Native Hawaiian or Pacific Islander O White O Other
Hispanic Origin	O No O Yes
2. *Date of Exam	____/____/_____ (mm/dd/yyyy)
3. Name of Person Who Completed this Paper Form	
*First Name	_____
*Last Name	_____

Note: Asterisked (*) fields indicate required data elements.