Oviedo Medical Research

REGISTRATION INFORMATION

For purposes of patient stipend delivery and coordination of care.

PLEASE PRINT CLEARLY AND COMPLETE ALL SECTIONS		
Last name:	First name:	MI:
Street Address:		Medicare ID #:
City:	State:	Zip Code:
Date of Birth: Age:		Gender: ☐ Male ☐ Female
Email 1:		Email 2:
Phone 1: ______________ ☐ Cell ☐ Home ☐ Work ☐ Allow sending text	Phone 2: ______________ ☐ Cell ☐ Home ☐ Work ☐ Allow sending text	Phone 3: ______________ ☐ Cell ☐ Home ☐ Work ☐ Allow sending text

DEMOGRAPHICS		
Race ☐ Caucasian ☐ Black/African American ☐ Asian ☐ Native American/Alaska native ☐ Native Hawaiian/other Pacific Islander ☐ Other	**Ethnicity** ☐ Hispanic/Latino ☐ Non-Hispanic/Latino	**Marital status:** ☐ Married ☐ Single ☐ Divorced Native language:

EMERGENCY CONTACT INFORMATION		
Primary contact name:		Relationship:
Main phone # ☐ Allow sending text	Alternate phone # ☐ Allow sending text	Email:
Secondary contact name:		Relationship:
Main phone # ☐ Allow sending text	Alternate phone # ☐ Allow sending text	Email:

PHYSICIAN CONTACT INFORMATION		
Physician's name:		
Street Address:		
City:	State:	Zip Code:
Main phone #	Date of last exam:	May we contact your physician? ☐ Yes ☐ No

METHODS OF CONTACT	
Allowed methods of contact	***Preferred*** methods of contact
☐ Phone 1 ☐ Phone 2 ☐ Phone 3	☐ Phone 1 ☐ Phone 2 ☐ Phone 3
☐ email ☐ Text messaging ☐ Mail	☐ email ☐ Text messaging ☐ Mail

PRIOR STUDY PARTICIPATION
Have you previously participated in other research studies? ☐ No ☐ Yes-date of last participation: ______________

I agree, as a guest of Oviedo Medical Research, LLC, to comply with the rights of privacy of any person(s) at the Oviedo Medical Research facility. I further agree not to disclose any information regarding any patient or client, which I may observe while visiting the Oviedo Medical Research facility. I also agree, to notify site staff prior to participating in any other research study during my participation with Oviedo Medical Research. I authorize all medical providers at Oviedo Medical Research to treat me medically in the office or hospital for any illness or injury that I may incur.

______________________________ ______________

Signature of Patient or Responsible Party Date

Obtained by:______________________________

Verbally In Person

Reviewed by (Coordinator initials)__________