PMG Research
Patient Information Sheet

Patient Name: _____
Last First M.I.

Preferred name or name you wish to be called:
_____

Address: _____
Street City State Zip Code

Telephone: (H) _____ (W) _____ (Cell)_____

Social Security Number: _____/_____/_____ Birthdate: _____/_____/_____

Sex: ( ) Male ( ) Female Race: _____

E-mail Address: _____

Known Drug Allergies or Sensitivities (Include Reaction if known): _____

_____

Personal Physician: _____

In Case of Emergency, Contact:

Name: _____ Relationship: _____

Address:
_____
Street City State Zip Code

Telephone: _____

Have you ever participated in a research study? ( ) Yes ( ) No

If yes, what type of study, and when did you last participate?
_____

I have received the Notice of Privacy Practices. ( ) Yes ( ) No
If No, comment: _____
A copy of the Notice of Privacy is always available upon request.

_____ _____/_____/_____

Signature of Research Volunteer Date

Revision Date: 11-3-08
Implementation Date: 1-2-09
Updated: 2-18-11