

Patient Information Form



Patient Information	Patient Information					
	Last Name:		First Name:		M.I.: Previous Name (if applicable)	
	Preferred Name:					
	Date of Birth:		Sex: Male Female	Email Address:		
	Address:		City/State/Zip:			
	Home Phone:		Cell Phone:		Work Phone:	
	Primary Care Provider:				Phone:	
	Have you previously participated in Clinical Research?		Yes	No		
	If yes, what type of study?			When did you last participate?		
	Emergency Contact Name:			Contact Phone #:		
	Relationship to Patient:					
	Do you have a Legal Guardian, Durable Power of Attorney or Health Care Power of Attorney (LAR)?		Yes	No		
	LAR Last Name:			LAR First Name:		
	LAR Address:					
	Phone Number:			Relationship to Patient:		
Additional Information	Race (please select):			Ethnicity (please select one):		
	White	American Indian or Alaska Native	Asian	Hispanic or Latino		
	Hispanic	Black or African American	Native Hawaiian or Pacific Islander	Not Hispanic or Latino		
	Other	Decline		Decline		
	Preferred Language (please select one):					
	English	Spanish	Russian	Other Please specify:		
Sign Language		Indian (including Hindi & Tamil)				
Please indicate how we may contact you with appointment reminders and other updates:						
Home Phone	May we leave a voicemail?	Yes	No			
Email	Cell Phone	May we leave a voicemail?	Yes	No		
Text Message	*Standard data and messaging rates may apply					
Please indicate how we may contact you with new study opportunities:						
Home Phone	May we leave a voicemail?	Yes	No			
Email	Cell Phone	May we leave a voicemail?	Yes	No		
Text Message	*Standard data and messaging rates may apply					
I have received a copy of Javara's Confidentiality Statement.		Yes	No			
I have reviewed a copy of the Study Doctor's Notice of Privacy.		Yes	No			
If No, comment:						
Patient Signature:			Date:			
Signature of Legally Authorized Representative (only if applicable):				Date:		
Print Name of Legally Authorized Representative:						