Patient Information Form

JAVARA

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):

☐ White ☐ American Indian or Alaska Native ☐ Asian
☐ Hispanic ☐ Black or African American ☐ Native Hawaiian or Pacific Islander
☐ Other ☐ Decline

Ethnicity (please select one):

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Decline

Preferred Language (please select one):

☐ English ☐ Spanish ☐ Russian
☐ Sign Language ☐ Indian (including Hindi & Tamil) ☐ Other Please specify:

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 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: