OAKLAND MEDICAL RESEARCH CENTER
REGISTRATION FORM

(Please Print)

PATIENT INFORMATION				
Patient's last name: First: Middle:				
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Birth Date:	Age:	Sex: ❑ M ❑ F
Street address:	Home Phone:	Cell Phone :		
P.O. box:	City:	State:	ZIP Code:	

ALTERNATE CONTACT INFO FOR EMERGENCY AND NON-EMERGENCY			
Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

Do we have permission to leave a message on your answering machine/voice mail/cell phone regarding appointments, or test results if necessary?

❑ Yes ❑ No May we call you at work? ❑ Yes ❑ No

Work Phone: _____

FINANCIAL ARRANGEMENTS

We are committed to providing you with the best possible care. ***You will NOT be responsible for any co-pays, deductibles, or non-covered services.*** In addition, ***IF*** stated in the Informed Consent Form, you will be compensated for your participation in the study. You will receive a final payment at the end of the study. If the study is not completed due to a screen failure or a premature withdrawal, compensation will be based on the amount of visits and type of visit completed. Should any problems arise affecting your compensation, we encourage you to contact us promptly for assistance.

Patient Signature: _____ Date: _____