Options Health Research
Registration Form

Name_____Age_____Date_____

Date of birth ____/____/____ Social Security number_____ Male___ Female___

Address_____ City_____ State_____ Zip Code_____

Phone Home(___)_____ Work(___)_____ Cell (___)_____

Email Address_____

Ethnic Origin: Caucasian ___ African American ___ Hispanic___ Asian___
Native American____ Other _____

Emergency Contact_____ Telephone (___)_____

Relationship to patient_____

Primary Care Physician_____

Referral Source: Newspaper_____ TV____ Radio____ Friend____
Flyer____ Physician_____ Other_____

All of the information provided by you will be kept confidential. You may be contacted by an employee of Options Health Research to establish eligibility in a clinical research trial. If you decide to participate, you will be under the care of a physician trained in the field of interest. You will receive any nursing care, laboratory tests, procedures and investigational or FDA approved medications required by the protocol at no cost to you. Care for any medical conditions other than those covered by the protocol will be your responsibility. All volunteers may decline participation at any time, for any reason.

I have read the above and give my permission to be contacted by Options Health Research. I am aware that I may contact Options Health Research for information or clarification regarding clinical research.

Signature_____ Date ___/___/_____