PatronMedical
Study Patient Registration Form

Patients Name:	Sex: M F	Date of Birth:_____/_____/_____ Age:_____	Marital Status: Single [ ] Married [ ] Divorced [ ] Widowed[ ]
Address:		Home Phone: Cell Phone:	Patients Social Security #:
City:		Email:	

Race: White [ ] Black /African American [ ] American Indian Alaskan Native [ ] Asian [ ] Other Island Pacific _____

Other Race: _____

Name of Employer **or Current Status**:	Occupation:	Work Telephone Number:
Address:		

Person to contact in case of emergency: Address:	Relationship to patient:	Emergency Phone Number(s):

Do you currently have a Primary Care Physician?

_____ **Yes**, I currently have a Primary Care Physician.

Name of Doctor:_____

Address: _____

Telephone:__(_____)_____

_____**No**, I do not have a Primary Care Physician.

_____**Dr. Andres Patron is my Primay Care Physician**.

May we contact your Primary Care Physician and request Medical Records ?

_____**Yes**, I give my Study Research Physician permission to request my records.

____**No**, I do not give my Study Reseach Physician permission to request my records

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_____ _____

Patient Signature **Date**