OFFICE USE ONLY

OREGON MEDICAL RESEARCH CENTER

NEW PATIENT INFORMATION

What condition brings you to our office?		How did you hear about us?	
First Name (full legal name)	Middle Initial	Last Name	
Date of Birth (month/day/year)	Age	Gender ❒ Male ❒ Female	Preferred Pronouns ❒ he, him ❒ she, her ❒ they, them
Mailing Street Address,		City, State, Zip	
Preferred Phone Number	Secondary Phone Number	Email Address	
Employer	Occupation		
Emergency Contact Name	Emergency Contact Number	Relationship	

Ethnicity: ❒ Caucasian ❒ Black ❒ Hispanic/Latino/Spanish ❒ American Indian or Alaska Native ❒ Asian Indian

❒ Chinese ❒ Filipino ❒ Japanese ❒ Korean ❒ Vietnamese ❒ Pacific Islander _____

❒ Mixed Ethnicity (specify) _____ ❒ Other: _____

❒ Parent / ❒ Guardian First Name **(IF PATIENT IS NOT 18)**		Middle Initial	Last Name
Preferred Phone Number	Secondary Phone Number		Email Address

If I enroll in a study, I understand that I will be contacted by any or all of the following methods for communications regarding the study: TEXT, VOICEMAIL, EMAIL _____ *initials*

Your privacy is important to us. Oregon Medical Research Center maintains all information related to patients and medical care in the strictest confidence. We will not distribute your personal information to anyone without your permission. By providing the information above (or by participating in a study) and by signing below, you give us permission to retain your information (contact, condition, study participation, and/or other limited medical information) whether or not you enroll in a study, so that we may contact you about future studies.

*If you do **NOT** want us to contact you about future studies please check here* ❒

*Signature*_____