

Volunteers in Medicine Patient Information Sheet

Label

(Please print clearly)

Last Name _____ **First Name** _____ **M I** _____ **Title** (Jr, Sr, etc.) _____

Sex: M F **Date of Birth:** ____/____/____ **Marital Status:** Married, Single, Divorced, Widowed, Separated, Life Partner

Race: Asian, Black, Native Amer, Pacific Isl, White **Ethnicity:** Hispanic, Non Hispanic **SS#** _____ - _____ - _____

Mailing Address _____ **City** _____ **ST** _____ **Zip** _____

Phone #'s: Home: (____) _____ - _____ Cell: (____) _____ - _____

Email: _____ **Access to Patient Portal electronic medical record?** YES or NO

Are you in a Clinical Research Study? ☐ Yes ☐ No

Guarantor Name (If other than patient): _____

DOB: _____

Relationship to patient: _____

EMERGENCY CONTACT:

Name: _____ **Relationship** _____ **Phone:** _____

Patient/Responsible Party Signature: _____ **Date** _____