

NORTHERN CALIFORNIA RESEARCH

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REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Name:		
<i>First</i>	<i>Middle Initial</i>	<i>Last</i>
Date of Birth: / /	Age:	Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male
SS #: / /	Marital Status:	
Address:		
City:	State:	Zip:
Home Number: () -	Cell: () -	
Work: () -	E-Mail:	

DEMOGRAPHIC INFORMATION

Race:	<input type="checkbox"/> Caucasian	<input type="checkbox"/> African American	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Asian	<input type="checkbox"/> Other:
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APPOINTMENT INFORMATION

Best day(s) & time(s) for Appointments:
Best day(s) & time to call you:

EMERGENCY INFORMATION

Emergency Contact:		
Phone: () -	Relationship:	
Address:		
City:	State:	Zip:

PARTICIPANT AGREEMENT

I understand that Northern California Research Corp. will not be providing investigational treatment for my medical condition unless I have qualified for and have entered into a research study. I also understand that if I do enter a study, I will only receive investigational treatment for the medical condition being studied.

Signature:	Date:
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Participant's Name: _____ DOB: _____
 First Middle Initial Last

ALLERGIES			
Any known allergies to medications, foods, dyes, plants, animals, etc?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
Do you have seasonal allergies?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
If "YES" to any allergies, please complete the table below:			
Allergen	Type of Reaction		First Noted (Date)

MEDICATIONS	List all medications currently used, prescribed by doctor or over-the-counter.					
Name of medication	Dose or Mg	# times taken daily	Reason taken	Start Date	Stop Date	Investigator or Sub Investigator Comments/Initials/Date

Tobacco Use: NO <input type="checkbox"/> YES <input type="checkbox"/>	What Kind?	# years used:	# per day:
Alcohol Use: NO <input type="checkbox"/> YES <input type="checkbox"/>	# of drinks per week:	# of drinks per month:	

CURRENT CONTRACEPTION / BIRTH CONTROL USE	
Are you using a method of birth control/contraception?	NO <input type="checkbox"/> YES <input type="checkbox"/>
If 'YES', what kind?	_____

WOMEN ONLY: MENOPAUSE HISTORY	
Are you Postmenopausal? <i>(Have not had a menstrual period in over 12 months)</i>	NO <input type="checkbox"/> If 'NO' Date of Last Menstrual Period: __ / __ / ____
YES <input type="checkbox"/>	If 'YES' how many years you've been postmenopausal?
<i>Indicate below whether you are naturally menopausal OR have had surgically induced menopause (ie. Hysterectomy)</i>	
Natural Menopause: <input type="checkbox"/>	Beginning Date of Last Menstrual Period: __ / __ / ____
Surgical Menopause: <input type="checkbox"/>	Type of Surgery:
PREGNANCIES AND BIRTHS	
# of Pregnancies:	# Full Term: # Miscarriage: # Abortion:
# of Births:	# Vaginal: # C-Section:

**The information I have provided as of today's date regarding my medical history is true and I understand that giving any false information may result in harmful treatment of my condition.*

Patient Initials: _____ Today's Date: _____

This authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My written revocation will be effective upon receipt, but will not be effective to the extent that the Requester or others have acted in reliance upon this authorization.

I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

<i>Check the box to specify which type of information is to be disclosed.</i>	
<input type="checkbox"/>	Medical Records
	Specify:
<input type="checkbox"/>	Psychiatric Information
<input type="checkbox"/>	Drug/Alcohol Information
<input type="checkbox"/>	HIV Blood Test

Study Protocol #:
Medical Record or Kaiser #:

If you are a Kaiser Patient please complete the Kaiser Release form on the next page.

PHYSICIAN INFORMATION	
Physician's Name (1):	
Address:	
Telephone:	() -
Fax:	() -
Physician's Name (2):	
Address:	
Telephone:	() -
Fax:	() -

_____	_____
Patient / Subject Signature	Date
_____	_____
Witness Signature	Date

Request for Taxpayer Identification Number and Certification

**Give form to the
requester. Do not
send to the IRS.**

Print or type See Specific Instructions on page 2.	Name (as shown on your income tax return)	
	Business name, if different from above	
	Check appropriate box: <input type="checkbox"/> Individual/Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ ----- <input type="checkbox"/> Exempt payee <input type="checkbox"/> Other (see instructions) ▶	
	Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
	City, state, and ZIP code	
	List account number(s) here (optional)	

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Social security number
or
Employer identification number

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Part II Certification

Under penalties of perjury, I certify that:

- The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
- I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
- I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here	Signature of U.S. person ▶	Date ▶
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General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

- Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
- Certify that you are not subject to backup withholding, or
- Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,