



New  
Horizon  
Research  
Group

Medical Affiliated Research Center  
303 Williams Ave. Suite 511  
Huntsville, AL 35801  
(256) 533 - 6603

North Alabama Research Center  
721 W. Market St. Suite B  
Athens, AL 35611  
(256) 771 - 9919

Cullman Research Center  
909 Graham St. SW Suite D  
Cullman, AL 35055  
(256) 735 - 4262

**Patient Information**

**Name:** (First) \_\_\_\_\_ (Middle) \_\_\_\_\_ (Last) \_\_\_\_\_

**Date of Birth:** (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_ **Age:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Home Phone:** (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **Cell Phone:** (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **Work Phone:** (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**How did you hear about us?** (Circle one):    Social Media    Friend/Relative    Melika/Serve    Radio    TV    Other: \_\_\_\_\_

**Your Email:** \_\_\_\_\_

**Demographics**

**Gender:** \_\_\_\_\_ **Marital Status** (check one):    \_\_\_Single    \_\_\_Married    \_\_\_Widowed    \_\_\_Divorced/Separated

**Height:** \_\_\_\_\_ ft \_\_\_\_\_ in    **Weight:** \_\_\_\_\_ lbs.

**Employer:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_ **Phone:** (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Primary Care Physician's Address:** \_\_\_\_\_

**Race (Check one OR more):**

- |                                     |   |
|-------------------------------------|---|
| _____ African American              | _____ Guamanian/Chamorro                      |
| _____ American Indian/Alaska Native | _____ Japanese                                |
| _____ Asian Indian                  | _____ Korean                                  |
| _____ Caucasian                     | _____ Native Hawaiian/Pacific Islander/Samoan |
| _____ Chinese                       | _____ Taiwanese                               |
| _____ Filipino                      | _____ Vietnamese                              |
| _____ Other: _____                  |   |

**Ethnicity (Check one):**

- \_\_\_\_\_ Hispanic, Latino or Spanish origin
- \_\_\_\_\_ Non-Hispanic, Latino or Spanish origin



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**Emergency Contact Information**

To whom may we speak with about your medical information? \_\_\_\_\_

Emergency Contact #1: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

(Relation to you – Check one):  Spouse/Partner  Child  Parent  Friend  Relative: \_\_\_\_\_

May we speak to this emergency contact about your medical information?  Yes  No

Emergency Contact #2: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

(Relation to you – Circle one):  Spouse/Partner  Child  Parent  Friend  Relative: \_\_\_\_\_

May we speak to this emergency contact about your medical information?  Yes  No

**Methods of Contact**

Preferred method of contact (Please check all that apply):

Phone call / Voicemail  Email  Other: \_\_\_\_\_

Preferred number (check one):  Home  Cell  Work

Do we have your permission to leave a voicemail about your appointment?  Yes  No

\*\*Would you like to join our monthly email newsletter and learn about our upcoming studies and events?  Yes  No

\*Sometimes the need may arise to contact our patients by text messaging. Do we have your permission to text you, if needed?

Yes  No Best number to text: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_