HARRIS COUNTY HOSPITAL DISTRICT
RESEARCH PATIENT REGISTRATION FORM

General Information: **This form is to be completed by research personnel and faxed to the Benefits Coordinator in the Pre-Registration Office @ 713.440.1102.**

CONTACT INFORMATION (For person completing the form)		
Name:		
Phone:	**Fax:**	**Email:**
LOCATION: ☐ **BTGH** ☐ **LBJGH** ☐ **QM** ☐ **CHP:**		
CLINIC/UNIT LOCATION (Enter unit name or clinic specialty and contact name , phone and email address)		
Unit Name/Clinic Specialty:		
Clinic Contact:	**Phone:**	**Email:**
SCHOOL AFFILIATION: ☐ **UTSHC-Houston** ☐ **BCM** ☐ **Other:** _____		
RESEARCH STUDY ACCOUNT (This information is needed at the intial set-up)		
Protocol Number:	**PI Name:**	
Billing Address:		
Phone:	**Fax:**	**Email:**
Adminstrative Contact:		
Insurance Plan Assigned:		
PATIENT REGISTRATION FOR RESEARCH ACCOUNT (This information is needed for each patient enrolled in the study) (Missing information will delay your ability to implement the protocol)		
Patient Name:	**MRN:**	**SSN:**
Date of Birth:	**Race:**	☐ **Male** ☐ **Female**
Billing Address:		
Mother's Name:		
Date Sumited:	**Enrollment Date:**	**Length of Time on Study:**
PATIENT REGISTRATION USE ONLY		
Date Received: _____	**Received By:** _____	
Date Entered: _____	**Entered By:** _____	