ACADEMIC DERMATOLOGY ASSOCIATES

ALICIA D. BUCKO, D. O.

EDUARDO H. TSCHEN, M.D.

PATIENT INFORMATION FOR CLINICAL STUDIES

First Name ____________________ **Middle Initial** _______ **Last Name** ____________________

SS# ____________________ Date of Birth ____________________ Age ____________

Home address ________________________________ City __________ ZIP Code ___________

Home Phone ________________ Work Phone _______________ Mobile Phone _____________

Employer ______________________________ Occupation ____________________________

Parent/Guardian Name (for minors) _____________________ Relationship __________________

Contact in case of emergency _________________________________ Phone _______________

Where did you learn about this study? __________ Primary Physician's Name _________________

I understand that I will be screened for a clinical study and can be excluded if I do not meet the criteria needed for entry. I will allow a visual inspection if indicated to determine that I have the condition to be studied. No study driven procedures will be performed until I have signed the informed consent. All information will be kept confidential in compliance with federal and state regulations and good clinical practices standards.

I will be given an informed consent prior to any procedures and after reading it I may ask as many questions as I need to understand the specifics about the study. My decision to participate can be delayed if I need additional time. I will receive a copy of the signed consent. The screening visit alone is performed at no cost and without reimbursement. Reimbursement for time and travel, if any, will be provided at my final study visit or thereafter and prorated depending of the number of visits completed, unless other arrangements are made and explained to me.

If enrolled in the clinical trial, I must adhere to the follow up schedule of visits and procedures. If I have questions during the study or thereafter, I am free to ask them. I also know that I can stop study participation at any time and will notify the office of my decision. If any changes occur in my health, medications, or address, I will notify the office. The study participation involves no cost to me. Costs of other treatments not study related are my responsibility.

Would you like to be contacted for future studies ___yes ___no **Email address** ________________________

______________________________________ ____________________

Participant's Signature Date

______________________________________ ____________________

Parent/Guardian's Signature (For minors) Date

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1203 COAL, S.E., ALBUQUERQUE, NM 87106 TELEPHONE (505) 247-4220 FAX (505) 247-0367 eatschen@aol.com