DHR Health
Institute for Research and Development
To Discover | To Innovate | To Excel

COVID-19 Booster Clinical Research Study Registration Form

Name: _____

DOB: _____ **Sex: Male** _____ **Female**_____

Marital Status: Single_____ **Married**_____ **Divorced**_____ **Widowed**_____

Race: Hispanic ____ **Asian** ____ **Black** _____ **Caucasian** _____ **Other:** _____

Preferred language: _____

Address: _____

Phone: (Home) _____ **(Cell)** _____

Email: _____

Insurance Company: _____

Subscriber #: _____ **Group #:** _____

Name of Insured on Card: _____

Have you recently tested positive for COVID-19? YES ____ **NO** _____

Have you had recent exposure to someone who is COVID Positive? YES ____ **NO** _____

What is the date of your last vaccination? _____

What type of vaccination did you receive? Pfizer_____ **Moderna**_____

Other: _____

Once Completed, please forward it by text: (956) 342-4896 (picture); or email: dhrresearch@dhr-rgv.com; or fax (956) 362-2383

For More Information Call: (956) 362-2357