Wake Forest™ Baptist Health

Instructions for completing this form:
1. Follow the formatting instructions.
2. Complete the form legibly.

BIOGRAPHICAL AND CONTACT DETAILS

First Name: _____ Middle Name: _____
Last Name: _____ Maiden Name: _____
Social Security Number *(last 4 digits only):* _____ Date of Birth *(format mm/dd/yyyy)*: _____
Gender: ○ Female ○ Male
Race: ☐ 2 or more races ☐ American Indian/Alask Native ☐ Asian ☐ Black/African American
☐ Hispanic/Latino ☐ Native Hawaiian/Other Pacific Islander ☐ White
☐ Other *(identify)*: _____
Address: *(Street/Apt #)* _____ *(City)* _____
(State Abbrev) _____ *(5 digit Zip)* _____

Phone Number *(format (xxx)xxx-xxxx)*: _____ Phone Type: ○ Business ○ Cell ○ Home
Mother's first name: _____
Have you ever worked at Wake Forest Baptist Medical Center or its affiliates? ○ Yes ○ No
Have you ever been seen as a Patient at our Medical Center? ○ Yes ○ No
Have you ever been seen in Employee Health? ○ Yes ○ No
Do you currently have an active WFBMC badge? ○ Yes ○ No
WFBMC Email Address *(if you already have one)*: _____ @wakehealth.edu
Other Email Address: _____

I hereby acknowledge that I have not misrepresented the information provided in this registration form. Accept this Day _____ *(1-31)* **of** _____ *(Month)*, _____ *(Year in format yyyy)*

☐ **If completed electronically, checking this box signifies an electronic signature.**

Name: _____