The Wellness Center of Tuscaloosa

Today's Date: _____ **Signature of Patient:** _____

Patient Title (check one) Mr. ___ Mrs. ___ Ms.___ Miss___ Dr. ___ Prof.___ Rev.___

First Name_____ **Nick Name**_____

Last Name_____ **Middle Name**_____ **Suffix**_____

Address 1_____

Address 2_____

City_____

State_____ **Zip Code**_____

Primary Phone_____ **Mobile Phone**_____

Home email_____

Place of Employment_____ **Employer Name**_____

Work Phone_____ **Ext**_____ **Work Email**_____

Contact Method (check one)

Primary Phone___ Mobile Phone___ Home Email___ Work Email___

Date of Birth_____ Age: ___ **Gender** (check one) Male____ Female____

Marital Status (check one) Single____ Married____ Other____

Employment Status (check one)

Employed____ FT Student____ PT Student____ Other____ Retired____ Self Employed___

SSN_____

Race (check one) White___ Black/African American___ Hispanic___ American Indian/Alaskan Native___

Asian___ Other____

Multi-Racial (check one) Yes___ No___ Unknown___

Ethnicity (check one): Hispanic or Latino___ Not Hispanic or Latino___ I choose not to specify___

Preferred Language (check one) English___ Spanish___ German___

Whom may we thank for referring you? _____