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 electron signature.**

**Name:** ____________________