# Memory Café Participant Registration Form

## Participant Name

| First | Last | M.I. |
|---|---|---|
| | | |

**Address**

| Address: | | City |
|---|---|---|
| | | |

| State: | Zip: | Telephone: Email: |
|---|---|---|
| | | |

## Additional Information

| DOB: / / Age: | Gender: ☐ M ☐ F | Veteran Status: ☐No ☐Yes ☐ Spouse veteran |
|---|---|---|
| | | |

| Allergies: | |
|---|---|
| | |

| Referral Source: | ☐ My doctor or care provider ☐ Word of mouth<br>☐ Community agency ☐ Other: _____<br>☐ Internet search<br>☐ Saw a flyer |
|---|---|
| | |

| Skills & Interests: | |
|---|---|
| | |

## Care Partner or Family Member Name

| First | Last |
|---|---|
| | |

| Address | City |
|---|---|
| | |

| State | Zip | Telephone: Email: |
|---|---|---|
| | | |

## Emergency Contact Information

Name_____Relationship_____

Telephone
Home_____Cell_____Work_____

☐ I consent that my image or likeness thereof may be used in promotional and marketing materials

☐ I release Age Well Arrowhead and its affiliates from any liability associated with participation in the Memory Café

How would you like us to contact you: ☐ Regular Mail ☐ Email ☐ Regular Mail *and* Email ☐ Phone

Enrollment Signature_____ Date_____