***Each new member must complete an application.*
One application does not cover the household.

TidalHealth Seniors

Membership Application

Please Print

Last Name	First	Middle	(check one) ☐ Rev. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

Street Address/ P.O. Box

City	State	County	Zip

Phone # (H)	(C)	(W)	E-mail Address

Gender ☐ Male ☐ Female	Age	Date of Birth Mo. Day Year

Race/ethnicity (This information will only be used to target programs/services to certain high-risk populations)

☐ American Indian or Alaskan Native ☐ Asian/Pacific Islander ☐ Black or African American ☐ Hispanic

☐ White/Caucasian ☐ Multiple ethnicity/other (please specify):

Social Security No.*	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widow(er)

Employer Name/Address	Check here if retired ☐

Former Occupation

Spouse's Name**	Spouse's Social Security No.*

How did you hear about TidalHealth Seniors? ☐ Mail ☐ Newspaper ☐ Hospital Department

☐ Website ☐ Family/Friend ☐ Presentation/Other (please specify):

Religious Preference (optional)

Special Needs/Medical History (check all that apply)

1. Asthma ☐	5. Eye Injury or Disease ☐	9. High Blood Pressure ☐	13. Lung Trouble ☐
2. Cancer ☐	6. Fainting Spells ☐	10. High Cholesterol ☐	14. Peptic Ulcer ☐
3. Diabetes ☐	7. Heart Trouble ☐	11. Kidney Trouble ☐	15. Rheumatism or Arthritis ☐
4. Depression ☐	8. Hernia ☐	12. Leg Pain ☐	Other: ____________________

Membership Application Authorization:

- I authorize TidalHealth Seniors to process this application in order to receive my membership benefits upon admission to TidalHealth (i.e., visitation program).
- I authorize TidalHealth Seniors to mail promotional and benefit material to my home (i.e., Wellness Wave newsletter, social/recreational announcements, etc.).
- I understand that if, at any time, I wish to have my name removed from the membership mailing list, I will need to make the request, in writing, and mail to: Program Coordinator, TidalHealth Seniors, 100 E. Carroll Street, Salisbury, MD 21801

* Social Security number is only used internally as a patient identifier. This information allows us to send gift bags to members when admitted to TidalHealth.

Signature____ Date____________________

Mail completed forms to: Program Coordinator, TidalHealth Seniors, 100 E. Carroll Street, Salisbury, MD 21801 or email to jessica.perry@tidalhealth.org.