Albert Pujols Wellness Center
For Adults with Down Syndrome
Client Registration Form

Date:

Client Information:

Full Legal Name: _____

Name Preference (nickname):_____Date of Birth _____

Address: _____

City: _____ State: _____ Zip Code: _____

Main #: _____Secondary #: _____

Email Address: _____

Primary Contact (Legal Next of Kin or Guardian):

Full Legal Name: _____

Relationship: _____ Legal Guardian? **YES** **NO**

Main #: _____ Secondary # _____

Address: _____

Email Address: _____

Additional contact:

Full Legal Name: _____

Relationship: _____ Legal Guardian? **YES** **NO**

Main #: _____ Secondary # _____

Address: _____

Email Address: _____

Name of Primary Care Physician (PCP): _____

Address: _____

City: _____State: _____Zip Code: _____

Telephone #: _____ Fax #: _____