Support Group Sign-In Form

Today's Date: _____

First Name: _____ Last Name: _____

Address: _____

Address Line 2: _____

City: _____ State: _____ Zip Code: _____

E-mail Address: _____ Telephone Number: _____

The following questions help our organization meet the needs of the community. Your answers will be kept confidential to the Alzheimer's Association.

Date of Birth: ☐☐ ☐☐ ☐☐☐☐
Month Day Year

Gender: ☐ Male ☐ Female

Education:
- ☐ Less than High School Degree
- ☐ High School Graduate
- ☐ Some College
- ☐ Bachelor Degree
- ☐ Post/Professional Degree

Race/Ethnicity:
- ☐ White
- ☐ Black/African American
- ☐ Hispanic/Latino
- ☐ American Indian/Alaskan Native
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ Asian
- ☐ Other Race
- ☐ Two or more races

Have you been diagnosed with one of the following:
- ☐ Alzheimer's disease
- ☐ A related dementia
- ☐ No diagnosis

-OR-

Has the person you care for been diagnosed with one of the following:
- ☐ Alzheimer's disease
- ☐ A related dementia
- ☐ No diagnosis

If you, or the person you care for has been diagnosed with Alzheimer's disease, please list the date of diagnosis:

☐☐ ☐☐☐☐
Month Year

Please indicate any Chapter resources you would like to receive:

- ☐ Add me to the Chapter mailing list
- ☐ Add me to the Chapter monthly newsletter list
- ☐ I would like more information about _____

Please contact me via: ☐ Telephone ☐ E-mail ☐ Postal Mail