



TANGER BE WELL FITNESS CENTER APPLICATION

The information you are providing is considered confidential and will not become part of your medical record. It will be kept on file in the Tanger Be Well Center Office.

Demographic Information

Name: _____
(First) (Last) (Middle Initial)

Social Security # last 4 digits 000 - 00 - _____

Date of Birth: ____ / ____ / _____ Gender: Male Female

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____

Primary Care Provider: _____

PCP Phone: _____ Fax: _____

Emergency Contact: _____

Relationship _____

Day Phone: _____ Evening Ph: _____

Referred to Tanger Be Well Center _____

Medical Information

1. Do you experience any of the following (please check all that apply)?

- | | |
|--|---|
| <input type="checkbox"/> Arthritis/Fibromyalgia* | <input type="checkbox"/> Cancer (past or present) |
| <input type="checkbox"/> Asthma* | <input type="checkbox"/> Family history of Heart Disease |
| <input type="checkbox"/> Diabetes* | <input type="checkbox"/> High blood cholesterol |
| <input type="checkbox"/> Epilepsy* | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Heart disease/chest pain* | <input type="checkbox"/> Metabolic disorders (hyper/hypo thyroid) |
| <input type="checkbox"/> Irregular heart beat* | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Neuromuscular disorders (MS, Parkinson's)* | |
| <input type="checkbox"/> Other _____ | |

* Medical clearance is needed for any conditions in bold



2. Do you have any current or past injuries that limit the movement of your muscles, joints or other part of your body (i.e., spine, knee, neck), and could be aggravated by exercise?
YES NO If yes, please explain:

3. Are you presently receiving physical therapy? YES NO If yes, for what reason?

Physical Therapist Name: _____ Phone: _____

4. What medication, vitamins, or hormones (either prescription or over-the-counter) are you presently taking or have just recently (within the past 3 months) completed taking?

5. Have you ever smoked? YES NO

Do you currently smoke cigarettes? YES NO

If yes, how many cigarettes per day? _____

If you've quit, how long has it been since you've smoked? _____ Months

6. How many times per week do you get aerobic physical activity, such as jogging, swimming, cycling, walking, or other activities that increase your heart rate? _____

On average, how long is each exercise session? _____

7. How many times per week do you get anaerobic physical activity, such as weight training and stretching/flexibility exercise? _____

On average, how long is each exercise session? _____

8. Do you have any exercise equipment at home? YES NO If yes, please describe:

I have read the above questions and have answered them to the best of my knowledge.

Signature _____ Date _____

Review by _____ Date _____

Comments _____



Beth Israel Deaconess
Medical Center



A teaching hospital
of Harvard
Medical School



FITNESS CENTER REGISTRATION & PAYMENT FORM

Please complete and return form to the Tanger Be Well Center front desk.

Demographic Information

Name _____
(Please print) Last First Middle Initial

Last 4 digits of S.S. # 000 - 00 - _____ Company _____

E-mail Address _____

Work Phone _____

Are you a BIDMC access cardholder? Yes No If yes, card # _____

Payment (please check one)

_____ Payroll Deduction: Weekly Deduction \$ _____ + \$50 Initiation Yes No

_____ Cash (community membership only) → Semi-Annually Payment Amount \$ _____

_____ Check (community membership only) → Paid Through: Date _____

_____ Charge (community membership only) → \$50 Initiation Fee Paid: Date _____

_____ Rental Locker # _____ (small / large) \$3.00/week (sm), \$4.00/week (lg)

Please Read & Sign

I hereby authorize Tanger Be Well to deduct the amount(s) indicated above in the total weekly amount of \$ _____, until otherwise notified. I understand that my membership is semi-annually and I may stop my deduction and terminate my membership only at the end of June or December by completing a drop form and submitting it to Tanger Be Well. Any questions that I have regarding the program or payment have been answered to my satisfaction.

Signature _____ Date _____