Healthy Hamilton
Fort Hamilton Hospital

2019 Living Well Program Exam Reporting Form

PLEASE PRINT CLEARLY

Employer: City of Hamilton Select One: Male ○ Female ○

First Name:______________________________ Last Name:__________________________________

Are you: City Employee ○ Covered Spouse ○ City Work Location (or Department): ____________________

Plan Coverage: Single ○ Employee+1 ○ Family ○ Social Security Number (last 4):__________________

If Employee+1 or Family Plan, list your spouse's first and last name: _______________________________

Date of Birth: _ _ / _ _ / _ _ _ _ Member Number (from Insurance Card): ______________________________

Home Address: ______________________________ City: __________________ State:_______ Zip:__________

Daytime Phone:______________________________ Email: ____

Preferred Means of Contact: Phone ○ Email ○

BIOMETRIC MEASURES	VALUE	TEST DATE (Month/Day/Year)
*Waist Circumference (inches)		
*HDL Cholesterol		
*LDL Cholesterol		
*Triglyceride Level		
*Total Cholesterol		
* Glucose Fasting		
Hemoglobin A1C (if physician recommended)		

Type of Service Provided: Complete Annual Physical *Date of Service: _ _ / _ _ / _ _ _ _

BIOMETRIC MEASURES	VALUE	TEST DATE (Month/Day/Year)
*Height (feet, inches)		
*Weight (pounds)		
*Systolic Blood Pressure		
*Diastolic Blood Pressure		

* On blood pressure medication? YES ○ NO ○

*Healthcare Provider (print name & location): ____

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*Signature of Healthcare Provider: ____ *Date:______________

Questions? Contact KHN Community Outreach at (800)888-8362 or via email at healthyhamilton@ketteringhealth.org

Submit this Registration Form and the Exam Reporting Form together:

- Scan and email to healthyhamilton@ketteringhealth.org
- Send via secure fax: (513)867-6900