Healthy Hamilton
Fort Hamilton Hospital

2020 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): _____

_____

*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

KETTERING Health Network