HealthAdvocate™
Always at your side

Physician
Health Screening Form

(Please print your name as it appears on your Anthem Benefits Card)

Last Name: _____ **First Name:** _____

Company: VAUMC **Zip Code:** _____ **Employee ID#:** _____ (optional)

Choose One: Employee ☐ Spouse ☐ **Current Age:** _____

Last 4 SS#: _____ **DOB:** _____ _____ _____ **Gender:** Male ☐ Female ☐
(Month) (Day) (Year)

Email Address: _____ **Phone:** _____

If for spouse, please list employee's name: _____

I authorize my healthcare provider to release the requested information to Health Advocate, Inc.

Signature: _____ **Date:** _____

Do not write below this line

To Be Completed by Physician Office

Please enter the results of the physical below and attach a copy of the lab work

Height: _____ FEET _____ INCHES

Weight: _____._____ POUNDS

Waist: _____._____ INCHES

Total Chol: _____

HDL: _____

Trig: _____

LDL: _____

Ratio: _____._____

Glucose: _____ OR HbA1c: _____._____

Blood Pressure: _____/_____

_____/_____/_____**DATE OF EXAM**

Patient Pregnant: Yes ☐ **No** ☐

Healthcare Provider Signature	Office Telephone Number	Signature Date

After providing any needed counseling on values obtained, please fax the results to Health Advocate at 610.397.7891. MUST BE FAXED FROM PHYSICIAN'S OFFICE.

Results may be verified with physician's office.

