



To provide health care to employee's spouses and dependents, please **PRINT** the following information.

First, MI, Last Name		Social Security #	Birth Date	Insurance Type
_____		_____	_____	_____
Address		City	State	Zip
_____		_____	_____	_____
Department	Home Phone	Work Phone	Primary Physician	
_____	_____	_____	_____	

SPOUSE/DEPENDENTS INFORMATION

(Legal Dependents Only – Must be able to provide documentation that they are claimed on yearly W2)

First, MI, Last Name	Social Security #	Birth Date	Relation	Insurance Type
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
Emergency Contact		Phone Number	Relation	
_____		_____	_____	

All information provided to Medical Analysis, LLC is solely for providing health care benefits to spouses and dependents. All information is maintained confidential.

I understand that the Employee Clinic is not a substitute for a Primary Care Physician. I am aware that the responsibility of initiating a yearly examination with a Primary Care Physician is encouraged by this clinical staff.

Consent for treatment

As the employee, I give Medical Analysis, LLC permission for any needed treatment for myself; and as a parent/legal guardian, I give Medical Analysis, LLC consent to treat any minors listed above.

Signature	Print Name	Date
_____	_____	_____

MEDICAL ANALYSIS, LLC

First, MI, Last Name

Social Security #

Birth Date

Phone Number

HEALTH PROBLEMS:

ALLERGIES:

PAST MEDICAL HISTORY:

Asthma Angina Anxiety Diabetes Depression

Hypertension Hepatitis Hyperlipademia MI

Seizure Disorder

CURRENT MEDICATIONS:

HEALTH MAINTENANCE: Date of last exams.

Breast: _____ Pap: _____ Mammogram: _____

Prostate: _____ Testicular: _____ CXR: _____

Foot: _____ Other: _____

SURGICAL HISTORY:

Appendectomy Bitutalligation Breast Augmentation C-Section

G-Bladder Hysterectomy Tonsillectomy

VACCINATIONS:

TT/TD: _____ Flu: _____ Pneumo: _____

Other: _____

FAMILY HISTORY:

Asthma Cancer Depression Diabetes CAD Hypertension

Thyroid DZ

SOCIAL HISTORY:

Marital Status: M S D W

Tobacco ETOH Drugs

LABS: DATA LAST RESULTS:

WP: _____ CBC: _____ UA: _____

URGG: _____ PSA: _____ TSH: _____

HAIC: _____ HEMOCCULT: _____

Other: _____

PATIENT PRIVACY QUESTIONNAIRE

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment and health care). Please note – If a patient is a minor and parents are divorced or separated, both parents have a legal right to the minor child’s health information unless otherwise permitted by a court of law. In this case, documentation will need to be provided.

Name	Phone	Relationship
_____	_____	_____
_____	_____	_____

2. Please list the family members or other persons, in any, whom we may inform about your medical condition ONLY IN AN EMERGENCY.

Name	Phone	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Please list the telephone numbers where you want to receive calls about your appointments, lab or x-ray results, or other health care information if other than your home phone: _____
4. May messages regarding appointment reminders be left on your telephone answering machine, voicemail or at your place of employment? YES NO
5. May confidential messages regarding medical treatment, x-ray results, or prescriptions be left on your telephone answering machine or voicemail? YES NO

Patient Name

Signature (Guardian if under 18 years of age)

SSN

DOB
