WELCOME TO THE WELLNESS CLINIC

In order to treat employee's spouses and dependents, we need the following information completed.

PLEASE PRINT

Employee's Name:_____ COMPANY NAME:_____

Badge #_____Department:_____ Date of Birth_____

Social Security #:_____-_____-_____Home #_____ Work #_____

Address:_____

Primary Physician:_____

Insurance information: Dental _____ Health _____

SPOUSE/DEPENDENTS INFORMATION (LEGAL DEP ONLY- MUST CLAIM ON W2)

NAME (First MI Last)	Social Security #	Birth Date	Relation	Insurance Type
_____	_____-_____-_____	_____	_____	_____
_____	_____-_____-_____	_____	_____	_____
_____	_____-_____-_____	_____	_____	_____
_____	_____-_____-_____	_____	_____	_____
_____	_____-_____-_____	_____	_____	_____

Please complete the following information.

Emergency Contact:_____Phone Number_____

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

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

Consent form for treatment

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

Dependants listed above have my permission to sign a payroll deduction form to pay for their services: Yes _____ No_____

Signature:_____Date:_____-