Cardiovascular Education Program

ENROLLMENT FORM

Please print clearly, fill out completely, sign and return to your regional office

NAME _____ (Last) _____ (First)

PHONE NO. (home) ___ - ___ - ____ (Area Code)

ADDRESS _____ (Street or P.O. Box)

PHONE NO. (work) ___ - ___ - ____ (Area Code)

CITY _____ STATE _____ ZIP _____ - _____

SOCIAL SECURITY NO. ___ - ___ - ____ (This will be your ID no. for this program.)

E-mail Availability: Yes / No (Circle one.)

E-MAIL ADDRESS _____

PHYSICIAN NAME _____ (Last) _____ (First)

ADDRESS _____ (Street or P.O. Box)

CITY _____ STATE _____ ZIP _____ - _____

In order to assist us in identifying health education needs, please answer the following questions by circling or completing the correct answer:

1) Please record your **most recent** blood pressure (BP) reading in the two blocks below:
   Top number (systolic): _____ example: 140
   Bottom number (diastolic): _____ 90

2) What is your current weight? _____ lbs.
   What is your current height? _____ inches

3) Are you a smoker? Yes / No

4) How many days of work did you miss last year due to a an illness related to your heart or blood pressure?
   A. 0 days B. 1-3 days C. 4-5 days D. More than 5 days E. Unemployed/Retired

5) How many days a week do you exercise for at least 30 minutes without stopping (example: walking, cycling, swimming — include walking breaks at work, taking stairs, gardening or household work.)?
   A. 0 days B. 1day/wk. C. 3 days/wk. D. 5 days/wk. E. Every day

6) Have you been diagnosed with diabetes? Yes / No

We are very interested in providing you with information regarding cardiovascular health. Please list below any topics that you would like to see included in the Cardiovascular Education Program materials. (Use the back of this form, if necessary.)

_____

_____

I understand and agree that the information provided on this form is to be used by Arkansas Blue Cross and Blue Shield, Health Advantage and BlueAdvantage Administrators of Arkansas to provide health educational and informational resources regarding cardiovascular health.

By my signature, I hereby indicate my decision to enroll in the Cardiovascular Education Program. I understand that there is no cost to me or my family for this program. I further authorize Arkansas Blue Cross and Blue Shield, Health Advantage or BlueAdvantage to communicate with my physician(s) regarding any related treatment or records of treatment, and to release my identity and related records for the purpose of my participation in the Health Survey and other aspects of the Cardiovascular Education Program as described in the Cardiovascular Education Program brochure.

Signature (Required): _____ **Date:** _____

Arkansas BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

Health Advantage
An Independent Licensee of the Blue Cross and Blue Shield Association

BlueAdvantage Administrators of Arkansas
An Independent Licensee of the Blue Cross and Blue Shield Association

Welcome to the Program!