ANNUAL PHYSICAL FORM

2026/2027

Complete an annual physical exam with your primary care provider. This helps monitor your overall health, detect potential issues early, and create a personalized plan for maintaining well-being. Please use this Annual Physical Form as proof of visit with your provider.

** Note to Health Care Provider: please do not provide any personal health information (PHI) on this form.*

Employee Name: _____
(Please Print)

Employee No.: _____

Provider's Office / Name: _____

Date of Visit: _____
(Must be between 9/1/2026 – 8/31/2027)

SCREENING TYPE

This **Proof of Visit** confirms that the patient above received an Annual Physical within the dates of **9/1/2026 – 8/31/2027**.

PROVIDER INFORMATION

I certify that the patient listed above received the exam(s) indicated on this form.

Provider Signature: _____ **Date:** _____

WellRight

ATLANTIC WELLNESS
YOUR JOURNEY STARTS HERE.