# PREVENTIVE CARE FORM

2026/2027

Please use the Preventive Care Form to show your proof of visit to any of the below preventive screening options. Complete the screening that is most appropriate for you — whether based on age or recommended by your doctor.

** 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 the following care within the dates of **9/1/2026 – 8/31/2027**:

- ☐ **Well-Woman Exam**
- ☐ **Mammogram**
- ☐ **Colonoscopy**
- ☐ **Dental Exam / Cleaning**
- ☐ **Skin Check**
- ☐ **Vision (Eye) Exam**
- ☐ **Prostate Exam**

## PROVIDER INFORMATION

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

**Provider Signature:** _____ **Date:** _____

WellRight

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