



Preventative Visit Insurance Coverage Form

You are scheduled for an annual physical. A routine annual physical is a preventive health visit you receive when you are symptom-free and includes routine labs and basic screenings.

Generally, the majority of insurance companies cover this visit at 100% with no member responsibility.

Your insurance coverage for a routine physical visit is different than your insurance coverage for an office visit.

The annual routine physical coverage provided by your insurance company does not include payment for services rendered for an illness, or related to other specific acute or chronic conditions.

While your appointment may be originally scheduled for a routine annual physical, if services are provided for other non-routine issues, an additional problem-related code may be billed.

We are legally obligated to assign procedure codes based on the services we provided to you, regardless of whether it was for an annual physical, a visit to address chronic or acute issues, or a combination of both.

We hope that this explanation will enhance your understanding, in advance of your appointment, of any future financial responsibility.

Kindly sign below to acknowledge your understanding of the above. Thank you.

Patient Name Printed

Date of Birth

Patient Signature

Today's Date

Review of Systems Form

Patient Name: _____

Appointment Date: _____

Please indicate if you are experiencing any of the following:

Constitutional		
Please check if all negative		
Negative	Positive	
		Chills
		Fatigue
		Fever
		Malaise
		Night sweats
		Weight gain
		Weight loss
Comments/Other:		
Head, Ear, Eyes, Nose, Throat		
Please check if all negative		
Negative	Positive	
		Ear drainage
		Ear pain
		Eye discharge
		Eye pain
		Hearing loss
		Nasal drainage
		Sinus pressure
		Sore throat
		Visual changes
Comments/Other:		
Respiratory		
Please check if all negative		
Negative	Positive	
		Chronic cough
		Cough
		Known TB exposure
		Shortness of breath
		Wheezing
Comments/Other:		
Cardiovascular		
Please check if all negative		
Negative	Positive	
		Chest pain
		Leg/Ankle pain (Claudication)
		Leg/Ankle swelling (Edema)
		Palpitations
Comments/Other:		

Gastrointestinal		
Please check if all negative		
Negative	Positive	
		Abdominal pain
		Blood in stools
		Change in stools
		Constipation
		Diarrhea
		Heartburn
		Loss of appetite
		Nausea
		Vomiting
Comments/Other:		
Genitourinary		
Please check if all negative		
Negative	Positive	
		Dribbling (Males)
		Painful urination (Dysuria)
		Blood in urine (Hematuria)
		Excessive urination (Polyuria)
		Slow stream
		Urinary frequency
		Urinary incontinence
		Urinary retention
Comments/Other:		
Male Reproductive		
Please check if all negative		
Negative	Positive	
		Erectile function concerns
		Penile discharge
		Sexual function concerns
Comments/Other:		
Female Reproductive/Breast		
Please check if all negative		
Negative	Positive	
		Abnormal Pap
		Pain during menstruation (Dysmenorrhea)
		Painful intercourse (Dyspareunia)
		Hot flashes
		Irregular menses
		Vaginal discharge
		Breast discharge
		Breast lump
Comments/Other:		

Review of Systems Form (Continued)

Patient Name: _____

Appointment Date: _____

Metabolic/Endocrine		
Please check if all negative		
Negative	Positive	
		Cold intolerance
		Heat intolerance
		Excessive thirst (Polydipsia)
		Excessive hunger (Polyphagia)
Comments/Other:		
Neurological		
Please check if all negative		
Negative	Positive	
		Dizziness
		Extreme numbness
		Extremity weakness
		Gait disturbance
		Headache
		Memory impairment
		Seizures
		Tremors
Comments/Other:		
Psychiatric		
Please check if all negative		
Negative	Positive	
		Anxiety
		Depression
		Insomnia
Comments/Other:		
Integumentary		
Please check if all negative		
Negative	Positive	
		Brittle hair
		Brittle nails
		Hair loss
		Unwanted, male-pattern hair growth in females (Hirsutism)
		Hives
		Itching (Pruritus)
		Mole changes
		Rash
		Skin lesion
Comments/Other:		

Musculoskeletal		
Please check if all negative		
Negative	Positive	
		Back pain
		Joint pain
		Joint swelling
		Muscle weakness
		Neck pain
Comments/Other:		
Hematologic/Lymphatic		
Please check if all negative		
Negative	Positive	
		Easy bleeding
		Easy bruising
		Swollen lymph nodes (Lymphadenopathy)
Comments/Other:		
Immunologic		
Please check if all negative		
Negative	Positive	
		Contact allergy
		Environmental allergies
		Food allergies
		Seasonal allergies
Comments/Other:		
Advance Directive		
Yes	No	
		Do you have a living will?
Name of durable power of attorney		
Additional Comments:		

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____

DATE: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

add columns + +

(Healthcare professional: For interpretation of TOTAL, TOTAL: please refer to accompanying scoring card).

10. If you checked off <i>any</i> problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	_____
	Somewhat difficult	_____
	Very difficult	_____
	Extremely difficult	_____