Prevent It Form

PROOF OF VISIT FORM

Patient's Name: ______________________________
(Please Print)

Patient Employee No.: ______________________

Physician Office/Name: _____________________________

Date of Visit: ___________________

This **Proof of Visit** confirms that the patient above received the following preventative care (Please check all that apply):

GENERAL

- ❑ **Dental Exam**
  (routine cleaning)
- ❑ **Eye Exam**
- ❑ **Other:** ________________

*Note: Your annual physical does not apply here. Please see the Say Aah challenge for your annual physical.

WOMAN

- ❑ **Annual OB/GYN Exam (pap)**
- ❑ **Mammogram**

MAN

- ❑ **Prostate Exam**

PHYSICIAN

- ❑ Yes
- ❑ No

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

Physician Signature: ______________________ Date: ________