

**PREVENTIVE CARE ACTIVITY FORM**



**FORM DUE DATE:** July 31, 2024

Previous exams will be accepted if they occurred on or after: August 1, 2023

**PATIENT INFORMATION:**

Last Name:	<input type="text"/>	Date of Birth:	<input type="text"/>	<input type="text"/>	<input type="text"/>
First Name:	<input type="text"/>	(Month)	(Day)	(Year)	

**COMPLETE ALL THAT APPLY**

Annual Physical	<input type="radio"/> Yes	<input type="radio"/> No
Covid Vaccine/Booster	<input type="radio"/> Yes	<input type="radio"/> No
Colonoscopy	<input type="radio"/> Yes	<input type="radio"/> No
Dental Exam	<input type="radio"/> Yes	<input type="radio"/> No
Eye Exam/Diabetic Retinal Exam	<input type="radio"/> Yes	<input type="radio"/> No
Flu Shot	<input type="radio"/> Yes	<input type="radio"/> No
Pneumococcal Vaccine/Booster	<input type="radio"/> Yes	<input type="radio"/> No
Mammogram	<input type="radio"/> Yes	<input type="radio"/> No

**HEALTHCARE PROVIDER PREVENTIVE CARE SIGNATURE**

By signing below, I attest that I have met with this patient and completed the preventive care exam(s) as indicated above.

Provider Signature (MD, NP, PA, DO, DDS, or DMD) : \_\_\_\_\_ Date of Exam:  (Month)  (Day)  (Year)

License #: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Once the form is complete and signed, return to the patient for submission.**

**PARTICIPANT SIGNATURE**

I hereby certify that the information included in this form is accurate to the best of my knowledge and I authorize this data to be provided to Bravo Wellness, LLC for the purpose of administering my employer's wellness program. (Refer to your Program Guide for privacy notice.)

**Participant Signature:** \_\_\_\_\_ **Printed Name:** \_\_\_\_\_

Upon obtaining your primary care provider's signature, please sign and return this form to Bravo Wellness, LLC for confidential tracking. The validity of this signature may be verified for authenticity. Falsification of information will be subject to disciplinary actions consistent with employee guidelines up to and including employment termination. If you have any questions, please speak with your human resources representative.

Do not return this form to your employer. You are responsible for submitting a completed form to Bravo by the due date above. Log into your [my.bravowell.com/proviso](http://my.bravowell.com/proviso) account to upload your form and track its status. You can also fax completed forms to 833-409-1339.

