

Definition of a Well-Care Visit

The focus of a well-care visit is preventive care. If tests or services beyond the scope of a well-care visit are provided, then additional charges may be incurred for those services. The choice to address both well care and medical issues is offered for the convenience of avoiding two visits. Although our office will assist you with your insurance processing, it is the patient's responsibility to understand their insurance benefits.

Please remember that Medicare and DSHS* do not cover well care visits.

| What is a Well-Care Visit? | |
|--|---|
| YES | NO |
| A review of your current health and medical history. | Treatment or consultation for a specific medical condition. |
| Counseling about ways to improve your health. | Any service not considered part of a well-care visit. |
| A physician exam tailored to your preventive care needs. | |
| Immunizations and screening tests, if needed. <i>(billed separately)</i> | |

Your scheduled appointment day is for an Annual Exam which is a well-care visit. Each insurance company has different contracts regarding group and individual coverage for Well Exam benefits. We do not know your contract so we cannot tell you if your insurance company is going to cover the charge for a well exam. If tests or services beyond the scope of a well-care visit are provided, then you may incur additional charges.

- ❖ If you are uncertain of your coverage, please contact your insurance company regarding benefits.
- ❖ I fully understand and agree to pay Inter Island Medical Center for this service if my insurance company denies my claim.

Signature

Date

Print Name

Date of Birth

* DSHS *does* cover well-care visits for children age 18 and younger.

CURRENT PROBLEMS OR CONCERNS:

(How long has this been a problem)

BODY SYSTEMS REVIEW: (Check any item that you are experiencing to any significant degree)

| | | |
|---------------------------------|--------------------------------------|------------------------------|
| _____ unexplainable fatigue | _____ chronic cough | _____ heartburn |
| _____ recurring fever/chills | _____ cough blood | _____ ulcer |
| _____ swollen glands | _____ pneumonia | _____ irritable bowel |
| _____ night sweats | _____ short of breath | _____ black or bloody stools |
| _____ weakness | _____ wheezing | _____ rectal bleeding |
| _____ weight problem | | _____ abdominal pain |
| | _____ chest pain | _____ constipation/diarrhea |
| _____ unconsciousness | _____ heart murmur | _____ loss of appetite |
| _____ frequent/severe headaches | _____ palpitations | _____ change in bowel habits |
| _____ fainting | _____ rheumatic fever | _____ hemorrhoids |
| _____ dizzy spells | _____ swollen ankles/feet | |
| _____ seizures | _____ leg pain with walking | _____ psoriasis |
| _____ head injury | _____ varicose veins | _____ eczema |
| _____ paralysis | _____ blood clots | _____ changing moles |
| | _____ anemia | _____ skin cancer |
| | _____ blood disease | |
| _____ trouble concentrating | | _____ ear/hearing problem |
| _____ memory problems | _____ bladder/kidney | _____ eye/vision problem |
| _____ tense/irritable | _____ infection | _____ glaucoma |
| _____ trouble sleeping | _____ difficulty urinating | _____ cataracts |
| _____ feel depressed | _____ frequent urination | _____ seasonal allergies |
| _____ work or family problems | _____ leaking urine | _____ sinus trouble |
| _____ thoughts about suicide | _____ kidney stone | _____ dental problems |
| _____ seeing a counselor | _____ infertility | _____ persistent hoarseness |
| | _____ sexual difficulties | _____ trouble swallowing |
| _____ knee/ankle problem | _____ prostate problems | _____ thyroid problem |
| _____ shoulder/elbow problem | _____ penile discharge | |
| _____ arthritis/joint pains | _____ lump on testicle | |
| _____ back/neck trouble | _____ urinate at night _____ time(s) | |
| _____ numbness/tingling | | |

WOMEN ONLY: Menstrual History

| | | |
|--|--|-------------------------------------|
| age of onset _____ | painful intercourse? _____ | number of pregnancies _____ |
| length of cycle _____ | previous sexual abuse? _____ | number of children _____ |
| days of flow _____ | do you perform self breast exam? _____ | type of birth control you use _____ |
| days of last period _____ | breast lump or cyst? _____ | history of abnormal pap? _____ |
| periods painful? _____ | menopausal symptoms? _____ | |
| unusual discharge? _____ | taking/taken hormones? _____ | |
| family history of osteoporosis / breast / cervical / uterine cancer? _____ | | |

NUTRITION: HOW MANY SERVINGS OF THE FOLLOWING FOODS DO YOU EAT?

PER DAY: meals _____ snacks _____ total cups of fluids _____ cups of milk _____
 breads & starches _____ fruits & vegetables _____

PER WEEK: eggs _____ red meats _____ cheeses _____ fish _____ fried foods _____
 desserts _____ chips / snack foods _____

SIGNATURE _____ **DATE** _____