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Routine Preventive Visit - Complete Physical Exam

Thank you for scheduling your routine complete physical exam with us! Preventive care and promotion of healthy lifestyles are central to Silver Pine's philosophy of care. For this reason, a routine preventive exam (or complete physical) is prevention focused, not problem focused. If you have a new or existing medical problem that needs attention, make a separate appointment to address those.

Insurance Coverage

It is your responsibility to confirm that you have coverage for your routine preventive exam. Typically, these are covered if it has been 12 months from your previous or every calendar year. If you have forms from your insurance or employer, bring them to your appointment.

Medicare patients

Complete the *Medicare Wellness Questionnaire* prior to your appointment. You can download it from our website or pick one up at the office. If you cannot, please come in 15 minutes before your appointment to allow time to complete the questionnaire.

Labs - Blood work

You should be fasting for blood work for your physical. Fasting is approx. 12 hours with no eating or drinking, except water. Drink plenty of water. Black coffee is also allowed.

Established patients: Please have your labs done at least one week prior to your appointment. Either obtain an order from us, or confirm that there is an order in your chart. Stop in during our open lab hours.

New patients: If your appointment is before noon, please fast for the appointment. If your appointment is in the afternoon, fasting is not required. We will provide you with an order to return for your blood work.

Cancellation

We reserve special time for your routine preventive exam. Therefore, failure to show for your scheduled appointment or cancelling with less than 24 hours' notice will result in a $50 charge.

Patient Portal

Prior to your appointment we encourage you to visit our website, www.silverpinedocs.com, to register for our patient portal. The patient portal allows you to communicate with our office and view your medical information.

For further information, please contact our office or visit our website. We look forward to seeing you at your appointment, and appreciate your trust in us to take care of your health needs. Thank you!

ROUTINE COMPLETE PHYSICAL EXAMINATION / PAP SMEAR CONSENT FORM

Thank you for scheduling your routine preventive exam with us.

Please be advised that routine examinations *may or may not* be a covered benefit with your insurance company. It is your responsibility to check with your insurance company prior to your appointment as to what your benefits are to avoid charges to your account.

Please find listed below the billing codes associated with the routine visits and tests that may be performed based on age and risk factors.

Service	Code
Routine Visits and Testing	
Routine Preventative Exam (code is age dependent)	99381 - 99397
Pap Smear	Q0091
Electrocardiogram	93000
Urinalysis	81002
Hemoccult	82274
Routine Blood Tests - billed as routine with diagnostic code V70.0 – routine medical exam	
Complete Blood Count with differential	85025
Comprehensive Metabolic Panel	80053
TSH - Thyroid Stimulating Hormone	84443
General Health Panel (combination of the above 3 tests)	80050
Lipid Panel	80061
PSA (males over 40)	84153
Additional Blood Tests, if necessary - billed as diagnostic, *not routine*, with appropriate diagnostic code	
Vitamin D	82306
Testosterone	84403
FSH - follicle stimulating hormone (females only)	83001
LH - luteinizing hormone (females only)	83002

By signing this form you understand and have agreed to pay any charges that your insurance carrier may not cover.

Patient Name: _____ Patient DOB: _____

Patient Signature: _____ Date: _____

Please bring this form with you the day of your exam. We must have a signed copy prior to your complete physical.

Name: **Birthdate**: SILVER PINE MEDICAL GROUP
Address:

Bring this to your **Annual Wellness Visit**

The names of all your doctors:

Name of Doctor	Doctor's Specialty

A list of all your medications:

Name of Medicine	Dose (if you remember)

		Circle one	
1.	Have any of your close relatives had any health changes?	Yes	No
2.	Do you worry about falling?	Yes	No
	Have you fallen 2 or more times in the past year?	Yes	No
3.	Are you worried about your memory?	Yes	No
4.	Are there any preventative tests you have done recently? (such as lab tests, mammograms, x-rays)	Yes	No
5.	Have you had any recent immunizations?	Yes	No
6.	Do you have a living will or advance directive? (if you have one, *please* bring a copy of it with you)	Yes	No
7.	Have you been given any information to help you with the following:		
	Hazards in your house that might hurt you?	Yes	No
	Keeping track of your medications?	Yes	No

8. Are you having difficulties driving your car?
   - Yes, often
   - Sometimes
   - No
   - Not applicable, I do not use a car

9. Do you exercise for about 20 minutes 3 or more days a week?
   - Yes, most of the time
   - Yes, some of the time
   - No, I usually do not exercise this much

10. How often during the past 4 weeks have you been bothered by any of the following problems?

	Never	Seldom	Sometimes	Often	Always
Fall or dizzy when standing up					
Sexual problems					
Trouble eating well					
Teeth or dentures					
Problems using the telephone					
Tired or fatigued					

11. How often do you have trouble taking medicines the way you have been told to take them?
    - I do not have to take medicine
    - I always take them as prescribed
    - Sometimes I take them as prescribed
    - I seldom take them as prescribed

12. How confident are you that you can control and manage most of your health problems?
    - Very confident
    - Somewhat confident
    - Not very confident
    - I do not have any health problems

13. During the past 4 weeks, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad, or downhearted and blue?
    - Not at all
    - Slightly
    - Moderately
    - Quite a lot
    - Extremely

14. During the past 4 weeks, has your physical and emotional health limited your social activities with family, friends, neighbors, or groups?
    - Not at all
    - Slightly
    - Moderately
    - Quite a lot
    - Extremely

15. During the past 4 weeks, how much bodily pain have you generally had?
    - No pain
    - Very mild pain
    - Mild pain
    - Moderate pain
    - Severe pain

16. During the past 4 weeks, was someone available to help you if you needed and wanted help? For example, if you felt very nervous, lonely, or blue, got sick and had to stay in bed, needed someone to talk to, needed help with daily chores, or needed help just taking care of yourself.
    - Yes, as much as I wanted
    - Yes, quite a lot
    - Yes, some
    - Yes, a little
    - No, not at all

17. During the past 4 weeks, what was the hardest physical activity you could do for at least 2 minutes?
    - Very heavy
    - Heavy
    - Moderate
    - Light
    - Very light

	Yes	No
Can you get places out of walking distance without help? For example, can you travel alone by bus, taxi, or drive your own car?		
Can you shop for groceries or clothes without help?		
Can you prepare your own meals?		
Can you do your own housework without help?		
Can you handle your own money without help		
Do you need help eating, bathing, dressing, or getting around your home?		