# 6 S R X V H Proof of Visit Form

Patient's Name: ______________________________________________
(Please Print)

Physician Office/Name: ______________________ Date of Visit: ______________________

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

☐ Annual Preventative Exam

Biometric Screening

PHYSICIAN:

Yes No I certify that the patient listed above received the exams indicated on this

form on:

Month: ______________________ Day: __________ Year: ______________

Physician Signature: ______________________ Date Signed: ______________________

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