Name _____ Date of Birth _____ Exam Date _____

Medicare Wellness Visit

Please take a moment to complete this form in order for us to best serve you. Thank you so much for trusting us with your health care. – The Dr. Phillips Medical Wellness Team

Allergies: _____

Tobacco use: ___Yes ____No

If yes, how much per day? _____

Alcohol use: _____

Drug use: _____

Please list any other providers regularly involved with your care:

Name _____ Specialty _____
Name _____ Specialty _____
Name _____ Specialty _____
Name _____ Specialty _____

Please describe your current diet (check all that apply):

___ Well-balanced, portion controlled ___ Unbalanced ___ Excessive portions

___ Low salt ___ Low fat ___ Low carbs ___ Restricted calories (_____cal/day)

___ Other: _____

Please described your current level of activity:

___ Minimal ___ Active, but no exercise ___ Some exercise ___ Regular exercise

General screening:

Do you have any significant safety concerns?	___Yes ___No
Do you have any trouble seeing, hearing or speaking?	___Yes ___No
Do you have any trouble bathing, dressing or eating?	___Yes ___No
Have you fallen or almost fallen in the last 60 days?	___Yes ___No
Any hospitalizations in the past year?	___Yes ___No
Do you have any fire hazards in your home?	___Yes ___No
Do you have any urinary concerns or incontinence?	___Yes ___No

Name _____ Date of Birth _____ Exam Date _____

Cognitive screening:

Do you feel you have any significant memory problems? ___Yes ___No

Have you ever gotten lost while driving? ___Yes ___No

End-of-Life Planning:

Dr. Phillips Medical Wellness Center honors our patients' end of life wishes, including: advanced directives, living wills and resuscitations desires...

Do you wish to discuss any end of life issues during this exam? ___Yes ___No

When was your last:

Colonoscopy_____

Fecal occult blood test_____

Dental exam_____

Eye exam_____

Podiatry visit _____

Bone density_____

Pneumonia vaccine _____

Flu vaccine _____

Tdap or TD vaccine _____

Shingles vaccine _____

Women:

Mammogram_____

Pap smear_____

Pelvic exam_____

DR. PHILLIPS MEDICAL WELLNESS CENTER | PRIVIA MEDICAL GROUP

ADVANCE DIRECTIVE FOR HEALTH CARE

I, _____ declare and make known that
Name of Individual Making This Advance Directive for Health Care (Declarant)
in the event that I am unable to make health care decisions on my own, my wishes are as follows:

NOTE: YOU MAY INCLUDE ANY OR ALL OF THE PROVISIONS IN SECTIONS I, II AND IV BELOW

SECTION I: APPOINTMENT AND POWERS OF MY AGENT

(CROSS THROUGH THIS SECTION IF YOU DO NOT WANT TO APPOINT AN AGENT TO MAKE HEALTH CARE DECISIONS FOR YOU)

A. APPOINTMENT OF MY AGENT

I hereby appoint the following individual(s) to make health care decisions for me if I am unable to do so:

_____ _____
Name of Primary Agent (s) E-mail Address

_____ _____
Home Address Telephone Number

If the agent named above is not reasonably available or is unwilling to act as my agent, then I appoint the following alternative individual(s) to serve as my agent:

_____ _____
Name of Alternate Agent (s) E-mail Address

_____ _____
Home Address Telephone Number

IMPORTANT: If I have named more than one individual to serve as my agent:

☐ I want such individuals to be able to act alone: OR

☐ Both/all such individuals must agree.

I grant my agent full authority to make health care decisions on my behalf as described below. My agent shall have this authority whenever, and for as long as I have been deemed by my physician to be incapable of making an informed decision. In making health care decisions on my behalf, I want my agent to follow my desires and preferences as stated in this document or as otherwise known to him or her. If my agent cannot determine what health care choice I would have made on my own behalf, then I want my agent to make a choice for me based on what he or she believes to be in my best interests.

B. POWERS OF MY AGENT

IF YOU APPOINTED AN AGENT ABOVE, YOU MAY GIVE HIM/HER THE POWERS SUGGESTED BELOW. CROSS THROUGH AND INITIAL ANY POWERS LISTED BELOW THAT YOU DO NOT WANT TO GIVE YOUR AGENT AND ADD ANY ADDITIONAL POWERS YOU DO WANT TO GIVE YOUR AGENT.

DR. PHILLIPS
MEDICAL WELLNESS CENTER

PRIVIA
MEDICAL GROUP

The powers of my agent shall include the following:

1. To consent to, or refuse, or withdraw consent to any type of health care, including, but not limited to, artificial respiration (breathing machine), artificially administered nutrition (tube feeding) and hydration (IV fluids), and cardiopulmonary resuscitation (CPR). This authorization specifically includes the power to consent to dosages of pain-relieving medication in excess of recommended dosages an amount sufficient to relieve pain. This applies even if this medication carries the risk of addiction or of inadvertently hastening my death.

2. To request, receive, and review any oral or written information regarding my physical or mental health, including but not limited to, medical hospital records, and to consent to the disclosure of this information as necessary to carry out my directions as stated in this advance directive.

3. To employ and discharge my health care providers.

4. To authorize my admission, transfer, or discharge to or from a hospital, hospice, nursing home, assisted living facility or other medical care facility.

5. To authorize my admission to a health care facility for treatment of mental illness as permitted by law. (If I have other instructions for my agent regarding treatment for mental illness, they are stated in a supplemental document)

6. To continue to serve as my agent if I object to the agent's authority after I have been determined to be incapable of making an informed decision.

7. To authorize my participation in any health care study approved by an institutional review board or research review committee according to applicable federal or state law if the study offers the prospect of direct therapeutic benefit to me.

8. To authorize my participation in any health care study approved by an institutional review board or research review committee according to applicable federal or state law that aims to increase scientific understanding of any condition that I may have or otherwise to promote human well-being, even though it offers no prospect of direct benefit to me.

9. To make decisions regarding visitation during any time that I am admitted to any heath care facility, consistent with the following directions: _____

10. To take any lawful actions that may be necessary to carry out these decisions, including the granting of releases of liability to medical providers.

ADDITIONAL POWERS OR LIMITATIONS, IF ANY: _____

_____

SECTION II: MY HEALTH CARE INSTRUCTIONS

YOU MAY USE ANY OR ALL OF PARTS I, 2, OR 3 IN THIS SECTION TO DIRECT YOUR HEALTH CARE EVEN IF YOU DO NOT APPOINT AN AGENT. IF YOU DO NOT PROVIDE WRITTEN INSTRUCTIONS, DECISIONS ABOUT YOUR CARE WILL BE BASED ON YOUR VALUES AND WISHES IF KNOWN, AND/OR IN YOUR BEST INTERESTS, AS DETERMINED BY YOUR PROVIDER. IF YOU ARE AN EYE, ORGAN, OR TISSUE DONOR, YOUR INSTRUCTIONS WILL BE APPLIED SO AS TO ENSURE THE MEDICAL SUITABILITY OF YOUR ORGANS, EYES, AND TISSUE FOR DONATION.

DR. PHILLIPS
MEDICAL WELLNESS CENTER

PRIVIA
MEDICAL GROUP

1. In the event my attending physician determines that my death is imminent (very close) and medical treatment will not help me recov then: (Only check one (1) box in this Part 1):
   - ☐ I do not want to receive any treatments to prolong the dying process. This includes: tube feeding, IV fluids, cardiopulmonary resuscitation (CPR), ventilator/respirator (breathing machine), kidney dialysis, or antibiotics. I understand that I still will receive treatment intended to relieve pain and make me comfortable; OR
   - ☐ I want to receive all treatments available to prolong my life as long as possible within the limits of generally accepted health care standards. I understand that I will receive treatment intended to relieve pain and make me comfortable; OR
   - ☐ Write your own instructions about the care you want at the end of your life, including specific instructions about treatments you dc want or don't want. (Please be sure your instructions here do not conflict with any other instructions you have given in this Advance Directive.)
2. If my condition makes me unaware of myself or my surroundings or unable to interact with others and it is reasonably certain that I wil never recover this awareness or ability even with medical treatment, then (Only check one (1) box in this Part 2):
   ☐ I do not want any treatments intended solely to prolong my life. This includes tube feeding, IV fluids, cardiopulmonary resuscitation (CPR), ventilator/respirator (breathing machine), kidney dialysis or antibiotics. I understand that I still will receive treatment to relieve pain and make me comfortable, OR
   ☐ I want to receive all treatments available to prolong my life as long as possible within the limits of generally accepted health care standards, I understand that I will receive treatment intended to relieve pain and make me comfortable, OR
   ☐ I want to try treatments advised by my physician for a reasonable period of time as determined by my physician in the hope of some improvement of my condition, in consultation with my agent. If I have appointed an agent. I understand that I still will receive treatment intended to relieve pain and make me comfortable, OR
   ☐ Write your own instructions about the care you want if you are unable to interact with others and are not expected to recover this ability, including specific instructions about treatments you do want or don't want. (Please be sure your instructions here do nor conflict with other instructions you have given in this Advance Directive.)

   _____

   _____

   _____
3. I provide the following additional instructions concerning my health care:
   NOTE, YOU CAN USE THIS SPACE FOR ANY INSTRUCTIONS NOT ALREADY COVERED IN THIS ADVANCE DIRECTIVE. PLEASE BE SURE YOUR INSTRUCTIONS DO NOT CONFLICT WITH OTHER INSTRUCTIONS YOU HAVE GIVEN IN THIS DOCUMENT.

   _____

   _____

   _____

SECTION III: IN CASE OF PREGNANCY *(Applicable only to residents of Georgia and Texas)*

I understand that under applicable state law, **SECTION II** will generally have no force or effect if I am pregnant unless the fetus is not viable.

SECTION IV: ANATOMICAL GIFTS

YOU MAY USE THIS DOCUMENT TO RECORD YOUR DECISIONS TO DONATE YOUR ORGANS, EYES, AND TISSUES, OR YOUR WHOLE BODY AFTER YOUR DEATH. IF YOU DO NOT MAKE THIS DECISION HERE OR IN ANY OTHER DOCUMENT, YOUR AGENT CAN MAKE THE DECISION FOR YOU UNLESS YOU SPECIFICALLY PROHIBIT HIM/HER FROM DOING SO, WHICH YOU MAY DO SO IN THIS ADVANCE DIRECTIVE OR SOME OTHER DOCUMENT. CHECK ONE OF THE BOXES BELOW IF YOU WISH TO USE THIS SECTION TO MAKE YOUR DONATION DECISION.

DR. PHILLIPS MEDICAL WELLNESS CENTER | PRIVIA MEDICAL GROUP

☐ I wish to donate my organs, eyes, and tissues for use in transplantation, therapy, research, and education. I direct that all necessary measures be taken to ensure the medical suitability of my organs, eyes, or tissues for donation. I understand that I may register my directions at the Department of Motor Vehicles or directly on the donor registry, and that I may use the donor registry to amend or revok my directions; OR

☐ I wish to donate my whole body for research and education.

Please provide any specific instructions you wish to give regarding anatomical gifts.

_____

_____

AFFIRMATION AND RIGHT TO REVOKE:

By signing below, I indicate that I understand this Advance Directive and I am willingly and voluntarily executing it. I also understand that may revoke all or any part of it at any time as provided by law.

_____	_____	_____
Signature or Declarant	Printed Name	Date

WITNESSETH
The declarant signed the foregoing advance directive in my presence.
TWO ADULT WITNESSES MUST SIGN THIS DOCUMENT. (NOTE: in Texas, a notary may sign below in place of witnesses.)

_____	_____	_____
Signature of Witness	Printed Name	Date

_____	_____	_____
Signature of Witness	Printed Name	Date

TEXAS ADVANCE DIRECTIVE SIGNED BEFORE NOTARY

AFFIRMATION AND RIGHT TO REVOKE: By signing below, I indicate that I understand this document and I am willingly and voluntarily executing it. I also understand that I may revoke all or any part of it at any time as provided by law.

_____	_____	_____
Signature of Declarant	Printed Name	Date

State of Texas. County of _____,
This document was executed before me on _____ by _____
(Declarant), who is personally known to me or provided appropriate identification.

SEAL

_____
NOTARY PUBLIC. State of Texas

Notary's printed name: _____ My commission expires: _____, 20____