Annual Wellbeing Visit Provider Form

Participant Name:	
Employer:	
Date of Birth:	**Last 6 digits** of social security number:
Phone number:	Email address:

Your health care provider's office must complete this form attesting to the results of the below biometric screening requirements. You must also complete the pre-screening questionnaire, located in the inHealth app under the Health Risk tab to earn the screening incentive.

The completed form should be emailed to service@inhealth4change.com no later than June 30.

Biometrics	
Height (in):	
Weight (lbs):	
Waist (in):	
BMI:	
Blood pressure:	
Pulse:	

Lab Results		
Fasting?	Yes	No
Blood glucose:		
Total cholesterol:		
HDL:		
LDL:		
Triglycerides:		

Annual Primary Care Wellness Visit		
Participant has completed an annual wellness visit with a primary care provider	Yes	No
Tobacco Status		
Participant has used tobacco products, including e-cigarettes, in the past 3 months:	Yes	No

Health Care Provider Name: _____

Health Care Provider Signature: _____ **Date:** _____

Questions? Call (800) 601-0175 or email service@inhealth4change.com