CLIENT INTAKE FORM

Follow-up Appointment Date: _____

How did you hear about us? _____

CLIENT INFORMATION

Name _____

Date of Birth _____ Gender _____

Phone _____ Email _____

Address _____ City _____ State _____ ZIP _____

Social Security Number _____ Medicare Number _____

Part A Date _____ Part B Date _____

Medicaid Number if Applicable _____

Retirement Date if Applicable _____

HOUSEHOLD INFORMATION

	Yes	No
Do you live with anyone?	☐	☐
If yes, how old are they? _____		
Are you married?	☐	☐
If yes, what is their name? _____		

Phone _____ Email _____

Do you have someone else who helps with medical decisions or has Power of Attorney (POA)?

Relationship _____ Name _____

Phone _____ Email _____

EMERGENCY CONTACT

Relationship _____ Name _____

Phone _____ Email _____

CURRENT INSURANCE

Company Name _____

Type of Coverage (Ex. ACA, Employee, Retiree, COBRA) _____

Cost _____ Purchase Date _____

Agent Name _____

INSURANCE QUESTIONS

	Yes	No
Did you work 40 Quarters (10 years)?	☐	☐
Did your spouse work 40 Quarters (10 years)?	☐	☐
Are you a veteran?	☐	☐
Do you have access to federal employee health benefits?	☐	☐
Did you pay into the teacher pension instead of Social Security?	☐	☐
Did you pay into an HSA when you worked?	☐	☐

If yes, how much is in this account? _____

PROVIDER & NETWORK QUESTIONS

Primary Care Doctor _____

Preferred Pharmacy _____

Preferred Hospital _____

Specialist Doctors _____

Dentist _____

Optometrist _____

Audiologist _____

HEALTH

Height _____ Weight _____

Do you have any major health concerns?

Heart Disease ☐	Diabetes ☐	Kidney Disease ☐
Stroke or Paralysis ☐	Crippling Arthritis ☐	Osteoporosis ☐
Cancer ☐	Alzheimer's or Dementia ☐	Parkinsons ☐

HEALTH *continued...*

	Yes	No
Do you use tobacco?	☐	☐
Do you use marijuana?	☐	☐
Do you use a walker or wheelchair?	☐	☐
Do you use Oxygen or a CPAP machine?	☐	☐
Do you go to a doctor's office to receive any medications?	☐	☐
Have you been hospitalized recently?	☐	☐

If yes, how long ago and what was the reasoning? _____

ADDITIONAL OUT OF POCKET EXPOSURE

Do you have a plan to pay for:	Yes	No
Nursing Home	☐	☐
Home Healthcare	☐	☐
Dental, Vision, or Hearing problems	☐	☐
Burial Expenses	☐	☐
Hospitalization	☐	☐
Non Medical Cancer Expenses	☐	☐

FINANCIAL QUESTIONS

	Yes	No
Do you own any annuities?	☐	☐
Do you have money in the stock market?	☐	☐
Do you have money in any investments?	☐	☐

If yes, who do you invest with? _____

Do you have a will or trust?	☐	☐

If yes, who did you work with to create them? _____

MEDICATIONS

List all drug names, dosage, frequency, retail/mail order, and reasoning. Please include any insulins, inhalers, creams or oitments.

Medication Name	Dosage	Frequency	Retail/Mail Order	Reason
Example: Metformin 24 hr	500mg	2 times / day	pharmacy pick-up	diabetes

SIGNATURE

I certify that everything listed is accurate as of the date below.

CLIENT SIGNATURE _____ DATE _____