

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

What type of market protection insurance do you have? _____

What type of longevity insurance do you have? _____

Do you have retirement accounts like a 401(k) or IRA

Yes No

that you'll use to cover your retirement expenses?

How much of those retirement accounts are you willing

to lose? All, some, or none? _____

Do you already own annuities?

If so, when were they purchased? _____

