CLIENT REVIEW FORM

Client Name _____

Medicare ID _____ DOB _____ Zip Code _____

Medicare Part A Effective Date _____ / _____ / _____

Medicare Part B Effective Date _____ / _____ / _____

Smoker __ Y ◯ / __ N ◯ Married __ Y ◯ N ◯

Have you had a change in health in the last 12 months? _____

Have you had a change in health in the last 24 months? _____

Current Health Coverage and Company _____

Initial Premium Amount $ _____ Current Premium Amount $ _____

Premium Payment Frequency: ☐ Annual / ☐ Semi Annual / ☐ Quarterly / ☐ Monthly

Current Medications _____

_____

Preferred Pharmacy _____

Doctor(s) _____

Desired Changes to Current Healthcare: _____

_____

Have you discussed with your family members of where and how you would like to be buried?

Have you or anyone else in your family ever had cancer or heart disease?

Have you had a need for dental services in the past 24 months?

Do you currently or have you ever had a family member use home health care or go into a nursing facility?

Have your current investments been affected by the stock market fluctuations?