Intake Form

Date:_____

Name: _____ Age:_____ DOB: _____

Address:_____

Phone: _____ Email: _____

Smoking Status: _____ Ht/Wt: _____

(highlighted areas are the min info required to get a good health risk assessment)

Health Issues	**Medications**	**Diagnosis Date & Date of Last Treatment**
Cancer/Heart Attack/Stroke/Diabetes:		
Lung/Respiratory Issues:		
Kidney/Liver:		
Other:		
Surgeries:		

DUI/Criminal History:_____

Existing Coverage: _____

Amount of Coverage Requested: _____

Monthly Budget Range For This Need: _____

Next Appointment _____

Option 1 **Option 2** **Option 3**