Health Insurance Quote – Medical Intake Form

Date: ___________________

First Name:______________________________ **Last Name:** __________________________________

Address: ____

City, State, Zip: ____**County:**__________________

Daytime phone: ___________________________**Cell phone:** ________________________________

Email: ________________________________

DOB: _________________________________ **Tobacco: Y or N**

Current Medications: ____

Spouse: _____________________________________ **Last Name:** _____________________________

DOB: _________________________________ **Tobacco: Y or N**

Current Meds/dosage/# of times daily: ____

Child First Name: _____________________________ **Last Name:** ______________________________

DOB: _________________________**Current Meds/dosage/# of times daily:** ____________________

Child First Name: ______________________________**Last Name:** _____________________________

DOB: _________________________**Current Meds/dosage/# of times daily:** ____________________

Previous Coverage: Y or N Company/Premium: ______________________________________

Current deductible:_____________________ **Desired deductible:** ___________________

Type of Family: Single Married Family

Type of Plan: PPO HMO HAS Other: ______________________________

Circle Co. Quoted: Aetna Assurant BCBSNC Celtic Humana United Wellpath

Comments: