Health Insurance Questionnaire: For help call Steck Johnson

615-771-8277 Office 615-429-8590 Mobile

Date/Time: _____Referred by:_____

Name: _____Address_____

Phone Number: _____ City and State_____

Age & D.O.B. _____County and Zip-Code_____

Are You Currently Insured: Y N If No, Why? _____

If Yes, Likes & Dislikes of Plan: _____Is plan ending? Y when? ___/___ N

Tax Credit? Y N Household Income 2019_____2020_____Estimated

amount _____ Current Insurance Company & Premium:_____

Budget: _____ Deductible: _____ Coinsurance: _____

What Would You Like Covered: _____

Effective Date/Begin Date: _____ Tobacco User? Y N

Spouse/Child/Children's Names, Age M/F & D.O.B.

_____

_____

Interested In: Dental/Vision: Y N, Accident/Critical Illness Deductible $250 option : Y N

Pre-Existing Conditions: _____

Prescriptions: _____

Doctors to find in Network_____

Email: _____ Best time of Day to Call:_____

Follow up Appointment: Date_____Time_____ AM PM APP ID___

Please scan and email to: JohnsonGA@buffalohealthadvisors.com