HEALTHCARE CHECKUP FORM

NAME: _____

ADDRESS: _____

CITY: _____ **ST:**_____ **ZIP:** _____

PHONE: _____ **COUNTY:**_____

EMAIL: _____

MEDICARE #: _____ **MEDICAID#:** _____

Part A Eff Date: _____ **Part B Eff Date:** _____

SSN: _____ **DOB:** _____

CURRENT PLAN: _____

PLANS TO PRESENT: _____

PCP: _____ **Provider ID#** _____

ADDRESS: _____ **PHONE:** _____

City: _____ **State:** _____ **Zip:** _____

EMERGENCY CONTACT : _____

Emergency Contact Ph# _____

☐ **DENTAL** ☐ **VISION**

PREFERRED HOSPITAL: _____

HOSPITAL IDEMNITY PLAN: _____

CANCER/HEART/STROKE/DIABETES: _____

LIFE INSURANCE: _____

REFERRAL NAME: _____

Healthcare Checkup Form Cont'd

Specialist (1)_____ Ph#_____

Address:_____

Specialist (2)_____ Ph#_____

Address:_____

Specialist (3)_____ Ph#_____

Address:_____

Specialist (4)_____ Ph#_____

Address:_____

Prescriptions: ☐ **Diabetic** ☐ **Heart Problems**

SOA Confirmation Code:_____

App Conformation Code:_____

HA Confirmation Code:_____

Voice Recognition ID:_____