Name:_____

Phone: _____

Email: _____

2027 office use
Date Received_____
Review: Good Needs Appt
Appt date:_____
Scope: Paper Online

Best way to contact you:
Phone_____ Text_____ Email_____ Any_____

1.) How do you feel about your current plan?

_____a. Want to stay with the plan. Please don't do anything. (no need to fill out the scope)

_____b. Like the plan but let me know if there might be sometime better.
Is dental important: _____ Yes _____No

_____c. Definitely want to change plans.

Main reason you want to change plans_____

_____

2.) Complete the list of medications
People usually remember to tell me all their prescription tablets and capsules but often forget to include things like their insulin, nasal sprays, asthma inhalers, creams, and ointments.

DON'T include medications that are otc (over the counter) or you get at the VA or that Worker's Comp pays for.

Drug	Strength	Form (tab, cap, spray etc)	How often

Preferred Pharmacy_____

3.) Do you receive Extra Help for your prescriptions:
_____ Yes _____ No

Doctors that you simply MUST HAVE in your plan:

First and Last Name	Phone number	City and Zip code

Additional comments:_____

_____