

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Best way to contact you:

Phone\_\_\_\_\_ Text\_\_\_\_\_ Email\_\_\_\_\_ Any\_\_\_\_\_

Reason for your appointment \_\_\_\_\_

1.) Do you have a current plan: ☐ No ☐ Yes, if so with whom \_\_\_\_\_

If yes, how do you feel about your current plan? \_\_\_\_\_

2.) What hospital system do you prefer: \_\_\_\_\_

3,) List your primary care doctor and any doctors that you would not be willing to give up

| Doctor's Name | Specialty | City | Phone number |
|---------------|-----------|------|--------------|
|               |           |      |              |
|               |           |      |              |
|               |           |      |              |
|               |           |      |              |
|               |           |      |              |

#### 4.) 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. Please include all.

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

[illegible]

5.) Preferred Pharmacy \_\_\_\_\_

6.) If you are Medicare, do you receive Extra Help for your prescriptions:  
\_\_\_\_\_ Yes                      \_\_\_\_\_ No

7.) Do you have Ohio Medicaid:        \_\_\_\_\_ Yes                      \_\_\_\_\_ No

Additional comments: \_\_\_\_\_

\_\_\_\_\_