2223 Brookstone Centre Pkwy, Ste A
Columbus, GA 31904
Office: 706-257-5073 Fax: 706-568-9979
Email: info@michellecrawfordbenefits.com

For Office Use Only

Date:
Entered:
Appointment Date:
Appointment Time:
Location:
Referred by:

CLIENT INFORMATION FORM 2023

All information contained in this questionnaire is strictly confidential
and used solely for seeking benefits to match the best plan for your needs.
*Consulting Agreement fee may be required.

Basic Information

Last Name	First Name	M.I.	Birthday:
Home Phone: ( ) -	Cell Phone: ( ) -	Okay to Text? Yes No	Gender: Male Female
		Tobacco Use? Yes No	County:
Home Address:			
Mailing Address if different:			
Email Address:			
Are you eligible to receive Medicaid? Yes No			
Do you receive any financial assistance (LIS/Extra Help)? Yes No			
Medicare ID #:	Part A effective date:	Part B effective date:	

Physician Information - (Only if considering an Medicare Advantage Plan)

Doctor	Type/Specialist	Location

Please List any Chronic Conditions (Heart Disease, Diabetes, etc.):

Preferred Pharmacy:

Medications

List your prescribed drugs

Name of Medication	Strength	Frequency Taken	Supply
			30 days / 90 days
			30 days / 90 days
			30 days / 90 days
			30 days / 90 days
			30 days / 90 days
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			30 days / 90 days
			30 days / 90 days

Additional Notes/Comments: