MEDICARE Review Questionnaire

NAME:_____ PHONE #_____ Home/Cell?

MAILING ADDRESS: _____

CITY, STATE, ZIP: _____

New address? ☐ Yes ☐ No

E-MAIL: _____

Driver's License#: _____ State: _____ Expiration: _____/ _____/ _____

Date of Birth: _____/ _____/_____

We will need copies of the following:

- ☐ Medicare Card
- ☐ Medical Insurance Card
- ☐ Prescription Card
- ☐ AARP Card (if member)

Medicare #: _____

Your Medicare Part A and Part B dates: Part A _____/ _____/ _____ Part B _____/ _____/ _____

Primary Care Physician: _____

Any chronic conditions? Yes No

Current Prescription Carrier: _____

Current pharmacies (including mail order):

_____ _____ _____

List of Current Medications – include dosage per pill and frequency

Medication	Dosage per pill	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Simmons Financial Partners, LLC