Client Intake Sheet

Print Name: _______________________________ Date of Birth: __________________

Social Security Number: _____-_____-______

Address: (Street)__________________(City)____________(State)______(Zip)__________

Phone: (home)______________ (cell)___________________

Email: ______________________________

Are you legally married? [ ] Yes [ ] No Spouses Name/DOB _____________________________

What is your combined monthly household income? $ ________________________

Source: SS Retirement $__________ SSDI $_________ SSI (1st of the Month) $__________

Employed: $________ Self Employed $________ VA $________ Pension $________

Other __________________________

List any assets (i.e., cash, checking, savings, stocks, etc.) and their value____________________

____

____

Your Medicare number _______-_____-_______

Part A Effective date _____________

Part B Effective date _____________

Do you also have private health insurance? [ ] Yes [ ] No If yes, what plan? ________________

Program Enrollment Information

Medicaid [ ] Yes [ ] No [ ] N/A QMB [ ] Yes [ ] No [ ] N/A LIS [ ] Yes [ ] No [ ] N/A

Are you a Veteran? [ ] Yes [ ] No

Do you receive prescriptions or Medical care from the VA? [ ] Yes [ ] No

Are you Disabled? _________ CSNPS: ESRD? _______ Diabetes? _____ CHF? __________

LIST YOUR PRIMARY DOCTOR AND SPECIALISTS

Doctor	Address	Specialty

PRESCRIPTION DRUGS

Drug Name	Dosage	# of Pills Taken Per Day

Which pharmacy and location do you prefer to use? ______________________________________

Website Drug List ID: ___________________ Password Date: ____________________

Special Notes:
____
____
____
____
____
____
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