Medicare Intake Sheet

What to Bring: 1. Medicare Card 2. Prescription list or Prescription Bottles

Name: _____DOB: _____ Age: _____

Spouse: _____ DOB: _____ Age:_____

Address:_____Phone: _____

Email: _____

Trusted Contact Name: _____Phone: _____

HEALTH COVERAGE:

Medicare Number: _____-_____-_____

Part A Effective Date: _____Part B Effective Date: _____

Do you have private health Insurance? Yes / No If yes, what plan? _____

PROGRAM ENROLLMENT:

Medicaid? Yes / No Qualified Medicare Beneficiary(QMB)? Yes/ No

Low Income Subsidy(LIS)? Yes/ No

Are you a Veteran? Yes/ No Do you receive prescriptions or medical care from the VA? Yes/ No

Are you disabled? _____

LIST YOUR PRIMARY DOCTOR AND SPECIALISTS

Doctor	Specialty

LIST YOUR PRIMARY AND PRESCRIPTION DRUGS

Prescription Drug Name	Dosage	Number of Pills Taken Per Day

Notes:

_____

_____

_____

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