



Medicare Intake Form

First / Last name _____ DOB _____

Address _____ City/State/Zip _____

County _____ Primary Phone _____ Gender _____

Medicare # _____ Tobacco Use Y/N _____

Part A Effective Date _____ Part B Effective Date _____

Current Health Insurance _____ Cost _____

Medical Concerns: heart, stroke, diabetes, cancer, and rheumatoid arthritis:

Physician Name	Specialty (Heart, OB, etc.)	Address	Phone Number

Dentist	Address	Phone number

Optometrist	Address	Phone Number

We are an independent insurance agency. Our firm is not affiliated with the U.S. government or the federal Medicare program.



How do you fill prescriptions: in-store, by mail, or both? _____

Retail Pharmacy Name _____

Location _____

Medication Name	Reason	Dosage	Frequency	Quantity

Medical Facility or Hospital	Address

Additional Considerations: _____

A to Z Retirement Planners

11427 Reed Hartman Highway, Blue Ash, OH, 45241

Office number: (513) 224- 7201/ Website: www.atozrp.com

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