MEDICARE INTERVIEW DATE: ______________

Name: **Phone:**

E-Mail: **Date of Birth:** **Current Age:**

* Best Time to Call:

CLIENT INFORMATION

Address:

City: **State:** **Zip:** **County:**

* Notes:

Retired: ___ No ___ Yes **Est Gross Income: ____ < $20k Annual ____ < $40k Annual ____ > $40k Annual**

Enrolled in Social Secuity: Yes No **Enrolled in Medicare: Yes No Auto** **VA Benefits: Yes No**

* Notes:

MEDICAL CARE

Current Health Plan: **Do You Have An HSA Account? YES NO N/A**

Primary Clinic: **Note:**

Specialist: **Note:**

Specialist: **Note:**

Specialist: **Note:**

Specialist: **Note:**

Preferred Hospital:

Primary Pharmacy:

Dental Office:

* Notes:

MEDICATIONS

	Medication	Dosage	Frequency
1.)			
2.)			
3.)			
4.)			
5.)			
6.)			
7.)			
8.)			

Notes:

TO-DO ITEMS

		Agent	Client	Complete

Client Source:		Agent:	
Recommendation:		Start Date:	

Medicare #		Part A:	Part B:

DATE and TIME	NOTES | COMMENTS