MEDICAL REVIEW FORM

Client Name _____

Address _____City _____Zip Code_____

Medicare ID _____ DOB _____

Medicare Part A Effective Date _____ / _____ / _____ Tobacco Yes ☐ No ☐

Medicare Part B Effective Date _____ / _____ / _____ Married Yes ☐ No ☐

Have you had a change in health in the last 12 months? _____

Current Health Coverage and Company _____

Current Premium Amount $ _____

Current Medications

Medication	Dosage	Daily Usage	Refill Frequency

Preferred Pharmacy(s) _____

Doctor(s)

Doctor Name	Specialty

J. D. Thompson Insurance Inc
3500 N Rock Rd # 300-A
Wichita, Ks. 67226-1330

Fax: 833-561-2600
Email: jdthompson@JDThompsonInsurance.com