Brooks Boyd
Licensed Agent
Senior Savings Organization
P: 281-542-8382
C: 713-927-8872

CONFIDENTIAL CLIENT INTAKE FORM

Personal Information

Name _____ Phone Number _____
Address _____
City _____ County _____ State _____ Zip code _____
Date of Birth ___/___/___
Email _____
Tobacco use? Yes ◯ No ◯
Referral Source _____

Medicare Questions

Medicare Number _____
Medicare Part A Effective Date _____
Medicare Part B Effective Date _____
If not eligible, date of eligibility _____
Medicaid, DUAL or LIS? _____

Medical Questions

Primary Care Physician	Medical Group(s)	PCP ID#	Accepting?	Existing Only?	Closed?

Specialists: (Name & Specialty)	Medical Group(s)	In Network?
		Yes ☐ No ☐
		Yes ☐ No ☐
		Yes ☐ No ☐

Preferred Hospital _____
Preferred Pharmacy _____

Medication	Dosage	Frequency	In Formulary?	Tier	Co-Pay

Current Coverage

Current Plan: _____
Coverage Type: _____
Company: _____
Plan Name: _____
Monthly Premium $ _____

Additional Benefits you may be interested in (check all that apply)

☐ Dental
☐ Vision
☐ Hearing
☐ Cancer Plan
☐ Hospital Indemnity Plan

Additional Information

Please add any other information you think would be of value