Health Info Sheet

FORMS RECEIVED AFTER 3 P.M. WILL BE PROCESSED THE NEXT BUSINESS DAY.
PLEASE FAX COMPLETED FORMS TO (770) 945-6809 OR EMAIL TO INFO@AMSPLANS.COM

TODAY'S DATE	DATE OF BIRTH	SSN

PRINTED NAME	CONTACT PERSON

CURRENT ADDRESS

CITY	COUNTY	ZIP CODE

HOW DID YOU HEAR ABOUT OUR COMPANY?

PHONE	MOBILE PHONE

EMAIL

HEALTH COVERAGE INFORMATION

ANNUAL INCOME (VOLUNTARY)

PLEASE CHECK THE FOLLOWING:

- ☐ I'm interested in a $0 deductible.
- ☐ I'm interested in dental & vision.
- ☐ My insurance need is short term.
- ☐ I have a need for maternity coverage.
- ☐ My insurance need is for the year.
- ☐ I will need a long term care plan.

NAME:________________________________

List Please include the actual name of prescribed medication, dosage amounts, and how often it is taken. If a vial, inhaler, etc – please list
approximately how many and of what volume are used monthly.

PRESCRIPTION DRUG LIST- PLEASE CALL OUR OFFICE IF YOU HAVE QUESTIONS.

PREFERRED PHARMACY NAME & CITY				
MEDICATION NAME	DOSAGE	TAKEN HOW OFTEN	REFILL HOW OFTEN	BRAND/GENERIC
				☐ ☐
				☐ ☐
				☐ ☐
				☐ ☐
				☐ ☐
				☐ ☐
				☐ ☐
				☐ ☐
				☐ ☐
				☐ ☐

NAME:______________________________

We can check to ensure your current doctors participate within the plan that we recommend.

PHYSICIAN'S LIST - PLEASE CALL OUR OFFICE IF YOU HAVE QUESTIONS.

PREFERRED HOSPITAL & CITY		
DOCTOR NAME	SPECIALTY	CITY LOCATION

WILL OTHER FAMILY MEMBERS NEED HEALTH INSURANCE?
If yes, please list their names and date of birth

NAME	DATE OF BIRTH