

Individual Health Insurance

Questionnaire

Household Name

Current Patient

Name:_____	DOB:_____	Gender:___	PCP:_____	Y/N
Name:_____	DOB:_____	Gender:___	PCP:_____	Y/N
Name:_____	DOB:_____	Gender:___	PCP:_____	Y/N
Name:_____	DOB:_____	Gender:___	PCP:_____	Y/N
Name:_____	DOB:_____	Gender:___	PCP:_____	Y/N
Name:_____	DOB:_____	Gender:___	PCP:_____	Y/N

Household Name

Smoker?

Tobacco user?

Name:_____	Y/N	Y/N
Name:_____	Y/N	Y/N
Name:_____	Y/N	Y/N
Name:_____	Y/N	Y/N
Name:_____	Y/N	Y/N
Name:_____	Y/N	Y/N

Home Address (including zip code/county):_____

Home Phone:_____ Cell:_____ E-mail:_____

Other Coverage

Is coverage available through employer? _____

If yes, who is eligible for employer coverage?_____

Date of coverage loss:_____ Reason for coverage loss:_____

Is COBRA offered?_____

Household Income

Number of people on tax return:_____ Annual Household Income:_____

Any additional options?

Dental/Vision: Critical Illness:

Accident: Life:

Notes