2223 Brookstone Centre Pkwy, Ste. A,
Columbus, GA 31904
O: 706-257-5073 F: 706-568-9979
E: info@michellecrawfordbenefits.com

For Office Use Only
Date:
ID:
Password:
Appointment Date:
Appointment Time:
Location:
AOR:
Referred by:

CLIENT INFORMATION FORM 2021

All questions contained in this questionnaire are strictly confidential and will become part of your client record.

Basic Information

Name: ☐ M ☐ F **DOB:**

FIRST MIDDLE LAST

Street Address: **Apt #:**

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

State of Birth: **Phone** **Okay to Text: Yes** ☐ **No** ☐

Email Address:

Tobacco Use? Yes ☐ **No** ☐ **Medicare ID/effective:**
Part A: **Part B:**

Are you eligible to receive Medicaid? Yes ☐ **No** ☐

Do you receive any financial assistance (with prescriptions)? Yes ☐ **No** ☐

Physician Information

Doctor	Type/Specialist	City Location

Please List any Chronic Conditions (Heart Disease, Diabetes, etc):

Do you have any referrals for us?

Name	Address	Phone

*Please flip this over and continue to page 2 of 2 of the Client Information Form

Medications: List your prescribed drugs, over the counter, vitamins and supplements

Name	Strength	Frequency Taken	30 Day or 90 Day Supply
			☐ 30 Day ☐ 90 Day
			☐ 30 Day ☐ 90 Day
			☐ 30 Day ☐ 90 Day
			☐ 30 Day ☐ 90 Day
			☐ 30 Day ☐ 90 Day
			☐ 30 Day ☐ 90 Day
			☐ 30 Day ☐ 90 Day
			☐ 30 Day ☐ 90 Day
			☐ 30 Day ☐ 90 Day
			☐ 30 Day ☐ 90 Day
			☐ 30 Day ☐ 90 Day
			☐ 30 Day ☐ 90 Day
			☐ 30 Day ☐ 90 Day
			☐ 30 Day ☐ 90 Day

Preferred Pharmacy: **Mail Order: Yes ☐ No ☐**

Additional Notes/Comments: