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

nexben™