OKEES INSURANCE AGENCY
Live Life Insured

HEALTH INSURANCE INTAKE FORM

Patient Information:

Full Name: _____

Date of Birth: _____ Age: _____ Gender: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone Number: _____ Email: _____

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed

Medical History:

- Do you have any pre-existing conditions? [ ] Yes [ ] No
  If yes, please list: _____
- Are you currently taking any medications? [ ] Yes [ ] No
  If yes, please list: _____
- Do you have any allergies? [ ] Yes [ ] No
  If yes, please list: _____

For Office Use Only:

- Date Received: _____
- Processed By: _____
- Verified By: _____
- Notes: _____