Health Info Sheet

There are fees required for our services. Please visit our website to learn more.

Please Fax to 770 945 6809 or Email to Info@amsplans.com

Tell Us About Yourself

Date _____ Date of Birth _____

Name _____

Address of Residence _____

County _____ City _____ Zip _____

Contact Person (if different from above) _____

Best contact information:

Phone _____ Alternate Phone _____

Email _____

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.

If other family members need health coverage, please refer to the bottom of page 3.

Medication 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.

What Medications do you Take?

Client Name _____ Date _____

Pharmacy Name _____

Prescription	Dosage	Frequency	check which one Brand or Generic	

Notes _____

Physician List

We may check to ensure your current doctors participate within the plan that we recommend. Please provide the names of any doctors you see on a regular basis, and please list their specialty and city location.

Which Doctor's Do You See?

Client Name _____ Date _____

Doctor Name	Specialty	Location

You are not required to submit medical, drug or physician information. It is entirely voluntary.

Will other family members need health insurance? If yes, please list their names and dates of birth.
