

Patient's Relationship to Insured: Self Spouse Child Other _____

Insurance Plan Name and Address _____

Please check if you have or had any of the following diseases or problems:

- | | | |
|---|--|---|
| <input type="checkbox"/> AIDS or HIV | <input type="checkbox"/> Fainting | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Allergies: _____ | <input type="checkbox"/> Glaucoma | Due Date: _____ |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Pacemaker | OTHER _____ |

- How would you describe your present health? Excellent Good Fair Poor
- Have you been admitted to a hospital or needed emergency care in the past two years? Yes No
If Yes, please explain: _____
- Are you under the care of a physician? Yes No
- If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Are you taking any medications? Yes No
If yes, please explain: _____
- Are you allergic to any medications? _____
- Do you have any health problems that need further clarification? Yes No
If Yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct.

Date: _____

Signature of Patient or Guardian Spouse