HEALTHCARE INFORMATION

Name: ____________________

Medical Condition(s): ____________________

Drug allergies: ____________________

Doctor's Name (first & last)	**Address**	**City, State, Zip**	**Telephone #**

Name Brand of PRESCRIPTION Medication (not the GENERIC)	**Strength**	**# of times daily**	**Doctor**	**Status (Office use only)**	**Rx Co (Office use only)**

Continue on back of page, if necessary

X____________________ X____________________
Signature of Participant Date

By signing this application you agree that all the information you have provided is correct. You also agree that you are responsible for reporting any changes in your financial situation or insurance coverage.