INSURANCE CENSUS FORM

SCAN AND EMAIL BACK TO:
Roger@legacyhealthconsultants.com or
Amanda@legacyhealthconsultants.com

FULL NAME OF EACH PARTICIPANT

	NAME	SEX	AGE	HEIGHT	WEIGHT
1					
2					
3					
4					
5					

	RELATIONSHIP TO #1	TOBACCO USER: YES OR NO?	CURRENT MEDICAL CONDITIONS
1	SELF		
2			
3			
4			
5			

PRESCRIPTION MEDICATION DETAIL

PARTICIPANTS NAME	MEDICATION NAME	DOSAGE	TREATS WHAT CONDITION?

SURGERIES AND HOSPITALIZATIONS IN THE LAST 10 YEARS

PARTICIPANTS NAME	DATE OF EVENT	DETAILS OF SURGERY OR HOSPITAL STAY

CONTACT INFORMATION

EMAIL	PHONE NUMBER	COUNTY OF RESIDENCE	ZIP CODE