OLSON INSURANCE
YOUR PARTNERS FOR LIFE & HEALTH

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Your Name: _____ Phone Number: _____

Your Address: _____ Medicare Part A & B effective date: _____

_____ Your DOB: _____

County: _____ Email Address: _____

Please tell us about your Providers:

Physician's Name	Specialty	Office Location: (city, state, zip)
Preferred Hospital(s):	**Preferred Pharmacy(ies):**	

Do you travel: Yes☐ No☐
If so, do you travel outside of the USA: Yes☐ No☐
How long are you usually away from home: DAYS☐ WEEKS☐ MONTHS☐ LONGER☒
Do you use tobacco: YES☐ No☐

Annual household income if under 65 _____

FOR OFFICE USE ONLY				
Atrio	HN	Reg	Prov	Other

Please tell us what prescriptions you CURRENTLY take:

Prescription Name:	Dosage: (strength)	Number of Doses per Month:

Any comments you would like to share? Enter comments here.