

Applicant's Social Security or ID No.

Prescription Medications – List all medications taken within the last 12 months by any family member listed on this application.

Family Member	Medication/Dosage/Frequency (i.e., Lopressor/100mg/daily)	Illness for which Medication is Prescribed	Date Prescribed (Mo/Day/Yr)	Date Discontinued (Mo/Day/Yr)	Name, Phone No. of Physician or Hospital
					Name: _____ Phone: _____
					Name: _____ Phone: _____
					Name: _____ Phone: _____

Professional Services

Give COMPLETE details in all sections below of any "Yes" answers to the questions in Section 6A.

Question #	Name of Family Member (As identified on Physician's Record)	Name of Hospital, Clinic and/or Person Providing Care	Phone No. ()
Date of Onset/Treatment (Month/Year)	Date Ended <input type="checkbox"/> Still under treatment	Physician Specialty <input type="checkbox"/> Pediatric <input type="checkbox"/> Cardiac <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Family <input type="checkbox"/> Other _____	
Name of Condition/Illness		Address	Suite No.
Treatment Rendered (i.e., X-ray, lab, surgical procedure, etc.) / Results		City / State / ZIP Code	Fax No. (Optional) ()

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Signatures (Required) – IMPORTANT: All applicants over age 18 must sign and date.

Applicant/Parent or Legal Guardian	Today's Date	Applicant's Spouse	Today's Date
Applicant's Dependent age 18 or over	Today's Date	Applicant's Dependent age 18 or over	Today's Date
Applicant's Dependent age 18 or over	Today's Date	Applicant's Dependent age 18 or over	Today's Date

