Barber Insurance Group

Medicare Benefits Check Up

Your Information		Spouse Information	
Name		**Name**	
Date of Birth		**Date of Birth**	
Phone Number		**Phone Number**	
Email Address		**Email Address**	
Primary Care Physician		**Primary Care Physician**	
Preferred Hospital		**Preferred Hospital**	

Your Current Prescriptions

Please list all of your current medications as they are written on your medication bottles.
Please do not include over the counter items.*

Prescription Name (ex. Lisinopril)	Dosage (ex. 20 mg)	Frequency (ex. 2x daily)

Your Spouse's Current Prescriptions

Please list all of your current medications as they are written on your medication bottles.
Please do not include over the counter items.*

Prescription Name (ex. Lisinopril)	Dosage (ex. 20 mg)	Frequency (ex. 2x daily)

What is your preferred pharmacy?	*If you need more space, please use the back to complete your lists.