SHORES INSURANCE

Please complete form and return to our office by email, fax, or US Mail
1530 W State St, Suite D, Meridian ID 83642
Email: support@shoresinsurance.net Fax: 208-321-4656
Phone: 208-321-4621

Prescription Drug/Physician Questionnaire

Name: _____Email: _____

Address: _____ Phone: _____

City: _____ State: _____County: _____ Zip: _____

Current Medicare Plan: _____ Medicare#_____ -_____-_____

Preferred Pharmacy: _____ Do you use Mail Order? Yes ☐ No ☐

Are you happy with your current policy? Yes ☐ No ☐

Please either copy your medication names right off of your pill bottles or obtain a current list from your pharmacist and attach it with this form.

Prescription Name:	Dosage:	Frequency:	Generic Y/N?

Please list your Doctor:

Primary Care: _____

Other Physicians/Specialists:

Specialist's Name: _____

Specialist's Name: _____

Specialist's Name: _____

Specialist's Name: _____

Are there any special needs or upcoming medical procedures that you may have?

_____