Douthat Insurance
DI
Dependable Integrity

NAME: _____ DATE: _____

ADDRESS: _____ DOB: _____

_____

PHONE: _____ CELL: _____

EMAIL: _____

MEDICARE ID: __ __ __ __ - __ __ __ - __ __ __ __ PART A EFF DATE: _____ PART B EFF DATE: _____

MEDIAL PROVIDER:

PCP: _____

Cardiology: _____

Rheumatology: _____

Dermatology: _____

Orthopedic: _____

Pulmonologist: _____

Endocrinologist: _____

Oncology: _____

Neurology: _____

Urology: _____

Nephrology: _____

Gastroenterology: _____

GYN: _____

Podiatrist: _____

Allergy: _____

Surgeon: _____

Chiropractor: _____

Eye: _____

Dental: _____

DME: C-pap _____

Bipap: _____

Oxygen: _____

Insulin Pump: _____

Wheelchair: _____

Prosthesis: _____

Other: _____

Hospital Other Than Ballad: _____

_____

Preferred or Current **Pharmacy:** _____

MEDICATIONS:

Please indicate any of the medications below you are currently using. Please include dosage and how often taken.

Advair
Alprazolam
Atorvastatin
Breo
Bupropion
Citalopram
Clopidogrel
Diazepam
Duloxtine
Eliquis
Escitalopram
Famotatidine
Furosemide
Humalog
Hydrochlorothiazide
Hydrocodone-acetaminophen
Isosorbide mon
Lantus
Levothyroxine
Lisinopril
Lorazepam
Losartan
Metformin
Metoprolol Succinate
Metoprolol Tartrate
Montelukast
Novolog
Omeprazole
Ozempic
Pantoprazole
Potassium Chloride
Pravastatin
Rosuvastatin
Sertraline
Simvastatin
Spiriva
Symbicort
Toujeo
Trelegy
Trulicity
Xarelto
Zolpidem

Please list any other medications you are currently taking that are not on the list above. Include dosage and frequency:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____