NAME: _____ Date of Birth: _____

Current Pharmacy:_____ Zip Code: _____

Tobacco Use: YES ☐ NO ☐ County:

2023 IEP

List the prescriptions you take.

Prescription name	Dosage of prescription (ml, mg)	Number of times a day you take your prescription	Amount you pay each month

OFFICE USE ONLY:

Today's date:_____ ID:_____

CURRENT PLAN:_____ P.W. DATE _____

PLEASE RETURN TO FIONA ALPAUGH -
VIA EMAIL - fiona@insuranceisboring.com
OR
VIA FAX - 214-443-1423