

Mailing Address:
175 Scott Swamp Road
PO Box 4058
Farmington, CT 06034-9863
Fax: (860) 674-2862

Supplement to SOLO® Application
GENERAL HEALTH QUESTIONNAIRE

1. Name of Primary Applicant: _____ . ID/SSN: _____ .
2. Patient Name: _____ .
3. Name of physician filling out this form(print clearly): _____ .
4. Current Height in office (Feet/Inches): _____ .
5. Current Weight in office (Pounds), with or without shoes? _____ .
6. Blood Pressure in Office: _____ .
7. Have there been any abnormal lab results during the last 5 years (i.e. cholesterol, blood glucose, etc.)? Yes or No: _____ . **If yes**, please attach a copy of these results to this Questionnaire. **If no**, or if this is the first time you are seeing this patient, were any tests ordered but not yet reported?

_____ .
8. Has this patient been experiencing **any** symptoms (including, for example: snoring, night sweats, rashes, shortness of breath, dizziness, chest tightness, vision problems, etc.) that he/she has not previously had checked by a physician? Yes or No: _____ . **If yes**, please list the symptom(s) and what follow-up, if any, is planned.

_____ .

For review and processing, please return this information in the envelope provided or for rapid processing, you may send this information to our confidential fax at: (860)-674-2862.

*******Please keep in mind that the more information we have and the more recent the information is, the sooner a final decision can be made regarding eligibility for insurance coverage.**

All of the above statements are true, complete and correct to the best of my knowledge. I understand and agree that this form is part of my patient's application for consideration of coverage and that ConnectiCare will also rely on these statements when determining eligibility.

Physician Address and Phone Number(print clearly): _____ .

Physician Signature: _____ .

Today's Date: _____ .