Denny & Associates, Inc.

2025 Consultation Questionnaire

Member Name: _____

Address: _____ City/State/Zip: _____

Phone Number: _____ Email Address: _____

Date of Birth: _____ Tobacco User: Yes or No

Dependents to be covered under Members application:

	Name	Date of Birth	Tobacco User?
Spouse:	_____	_____	_____
Child:	_____	_____	_____
Child:	_____	_____	_____
Child:	_____	_____	_____
Child:	_____	_____	_____

Please indicate any Hospital/Doctor Networks below that you prefer In-Network on your plan:

____ **BJC** (includes but not limited to Barnes, Christian, St. Louis Children's, Missouri Baptist, Progress West)

____**Mercy**

____**SSM** (includes but not limited to St. Mary's, DePaul, Cardinal Glennon, St. Clare, St. Joseph (West), SLU)

____**St. Lukes**

____**Other**: _____

____**No Preference**

Please list names, specialty, and location of any physicians preferred In-Network on your plan:

_____

_____

_____

Denny & Associates, Inc. – 1022 Peruque Crossing Ct., Suite B – O'Fallon, MO 63366
Phone: 636-887-4700 - Fax: 636-887-3081
www.dtdinsurance.com

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Please list medication names and dosage for anyone enrolling on the plan:

_____

_____

_____

The following information is helpful for comparison:

Current Insurance Carrier: _____ Current & Renewal Premium: _____

Current Plan Design (Name or Deductible/Co-Insurance): _____

Would you like to see quotes on any of the following options?

_____Dental _____Vision _____Life

Preferred Consultation Time
Please indicate preferences below:

Consultation Preference: In-Person Meeting OR Virtual Meeting

Day of Week: M T W TH F SAT SUN Time: Morning Afternoon Evening

Time: Morning-8:30am-11:30am, Afternoon-12:00pm-4:00pm, Evenings-5:00pm-7:00pm

*Limited Evening and Weekend appointments available

Meetings will be held from November 4th – December 13th for a January 1st effective date.

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