OFF GRID DOC
PATIENT REGISTRATION

Name: _____Today's Date: _____

Marital Status: S M W D SEP Sex _____ Age: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: Home: _____ Cell:_____ Email: _____

Occupation: _____ Employer: _____

Spouse Name: _____

Spouse Employer and Phone: _____

If Minor Child, Parents Info:

Mother: _____Phone: _____

Address: _____

Father: _____ Phone: _____

Address: _____

Emergency Contact:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Pharmacy you prefer: _____

Membership Options (choose one)

- Direct Primary Care — Date Enrolled: _____
- Medical Weight Loss Intensive — Date Enrolled: _____
- Medical Weight Loss Maintenance — Date Enrolled: _____
- Metabolic Health Consultation — Date Seen: _____
- Medical Second Opinion — Date Seen: _____
- Urgent Care Visit — Date Seen: _____

Signature: _____ Date: _____

Yearly Updates

I have reviewed this information. It is correct or I have made any necessary changes.

Initials & Date _____

Initials & Date _____

Initials & Date _____

Initials & Date _____