Meet & Greet Information

Name: _____ Today's Date: _____

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

Street Address: _____

City: _____ State: _____ Zip Code: _____ Email: _____

Phone: Home: _____Cell: _____ Occupation: _____

Spouse Name: _____ Number of minor children living at home _____

How did you hear about us? _____

What prompted you to contact us? _____

Do you have insurance? Yes No If so, which one? _____

Do you have a Primary Care Provider? Yes No If so, which one? _____

Do you see any Specialists? Yes No What kind? _____

What types of medical problems do you usually see a physician for? _____

_____

When was the last time you saw a physician? _____ What was it for? _____

What medications do you take? Check those that need to be refilled. _____

_____

_____

What service(s) are you interested in?

_____ Direct Primary Care

_____ Medical Weight Loss

_____ Medical Consultation

_____ Metabolic Consultation

_____ Diabetes Reversal

_____ Reducing or Eliminating Prescription Medications

_____ Intermittent Fasting

_____ (Ketogenic Diet) Keto

_____ Low Carbohydrate Diet

How concerned are you about Covid 19?

Not Concerned Concerned Very Concerned

0 1 2 3 4 5

How concerned are you about the Covid 19 vaccination?

Not Concerned Concerned Very Concerned

0 1 2 3 4 5

What are your concerns about Covid 19 or the vaccination? _____

_____

_____

Please email completed form to office@offgriddoc.com