ROBINSON MD
FUNCTIONAL & CONCIERGE MEDICINE

Getting to Know You…….

Date: _____

Name: _____ DOB: _____ Age: _____

Address: _____

Preferred Phone: _____A.M./P.M.

E-mail: _____

- **Were you referred to the practice? If Yes, by whom? _____**
- **Occupation_____**
- **Business Owner? YES/NO**
- **If you found our practice through an internet search, what were you searching for?**
  _____
- **Would you like to receive Dr. Robinson's newsletter? _____**
- **Have you reviewed our website? YES/NO**
- **What appeals to you about the practice?**
  _____
- **Do you have insurance? If Yes, please list insurance company name:**
  _____
- **Is your insurance an HMO? _____**
- **Do you take any controlled medications for the following conditions? If yes, please indicate below with corresponding medication name:**
  - ☐ **Narcotics for Chronic Pain _____**
  - ☐ **Attention Deficit Disorder (ADD) _____**
  - ☐ **Anxiety (Xanax, Valium, etc.) _____**
  - ☐ **Weight Loss _____**