

New Patient Intake Form

Please fill out this form completely. No line should be left blank.

Name: _____ OFFICE USE ONLY Patient # _____
Date of Birth: _____ Age: _____ Sex: M or F *(circle one)*
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell: _____ Email: _____
CA Driver's License #: _____ or State ID Card #: _____
How did you hear about us?: _____

Your Medical Information

Please list medications, both prescription and over- the- counter: _____

Please list all allergies or side effects to medications: _____ (side effects may be one reason to use medical marijuana instead of pills)

Your Last Medical Doctor or Clinic Visit

Name: _____ Phone: _____ Fax: _____

Date and Reason for the visit: _____

(If you DO NOT Remember your last doctor's visit, please write I DO NOT REMEMBER across this section)

1. What medical issue will you be seeing the doctor for today _____
2. What caused your problem: _____
3. How long have you had these symptoms: _____

Do you wish to be reminded of your renewal ? Y/N

Email: _____

Disclosures and Conditions

- Based on my beliefs and awareness of researched scientific evidence of the benefits of medical marijuana, I request that the doctor evaluate me for a recommendation to us medical marijuana. This would enable me to legally obtain medical marijuana to use for treatment of my medical conditions.
- If medical marijuana adversely affects my health, I will stop using medical marijuana. I assume all risk for the use of medical cannabis.
- I agree to obtain medical follow-up at my personal medical doctor's office, or obtain a personal doctor I have none now and to return this office for follow-up as recommended by the physician. I understand this is an obligation on my part for the continuity of care.
- I agree NOT TO DRIVE or operate heavy equipment while using medical marijuana.
- I DO NOT plan or intend to use my physician's recommendations for the purpose of illegally obtaining medical marijuana.
- I understand that by signing below, that the physician you see, is a medical cannabis evaluator and NOT my primary care physician and will not provide services as such.
- I affirm that I have a serious medical condition that adversely affects my quality of life.
- I have been assured that medical records relating to my care will be kept private and confidential and that no information will be released or printed, which would disclose my personal identity, unless required by law.
- It should be made absolutely clear that the physician, staff or representatives of this center are neither providing medical marijuana, nor are they encouraging any illegal activity in my obtaining or using medical marijuana.
- Furthermore, the undersigned, my heirs, assignees, or anyone acting on my behalf, hold the physician, the staff or any agents of this center free and harmless of any liability resulting from the use of medical marijuana.

I have read, understood and affirm all of the above statements.

X _____ Date: _____

Please return this form to Khristie at the front window when you are finished. Thank you!