COMPASSIONATE
HEALTHCARE OF FLORIDA

PATIENT REGISTRATION FORM

Patient's Name (Last): _____ (First): _____ (Middle Initial): _____

Primary Phone Number: _____ □ Home □ Cell Secondary Phone Number: _____

E-Mail Address: _____

How did you hear about us?
□ Google □ Yahoo □ Bing □ Facebook □ Company Website
□ Website (Other): _____

Home Address: _____

Referred by (Name): _____
(Phone): _____

City: _____ Zip: _____ State: _____

Date of Birth: _____ Age: ____ Sex: □ Male □ Female Social Security Number: _____

Florida Resident Status: □ Full-time □ Seasonal

Marital Status: □ Married □ Single □ Divorced □ Widowed

Employment Status: □ Full-time □ Part-time □ Student
□ Retired □ Unemployed

Emergency Contact: _____ Relationship to Patient: _____

Phone number: _____

RESPONSIBLE PARTY INFORMATION (**IF OTHER THAN PATIENT**):

Name: _____ Relationship to Patient: _____

Address: _____ Phone Number: _____

E-Mail Address: _____ Date of Birth: _____

RELEASE OF INFORMATION

I hereby give permission to the person(s) listed below to receive information about the care of the above-named patient.

Name(s): _____ Relationship to Patient: _____

_____ Relationship to Patient: _____

Patient / Parent or Guardian Signature: _____ Date: _____

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HEALTH HISTORY

Which condition are you requesting medical marijuana treatment for?

☐ Cancer ☐ Epilepsy/Seizures ☐ Glaucoma ☐ HIV/AIDS ☐ PTSD ☐ ALS ☐ Crohn's disease
☐Parkinson's disease ☐ Multiple Sclerosis ☐ Terminal Condition ☐ Chronic Nonmalignant Pain
☐ Other Condition (Please name): _____

Have you used Marijuana before? **Female Patients:** Are you currently pregnant? ☐ Yes ☐ No

☐ Yes ☐ No **Female Patients:** Are you Breastfeeding? ☐ Yes ☐ No

Has any other physician evaluated you for the use of medical marijuana in the past?

☐ Yes ☐ No Name: _____ Phone: _____

Primary Care Doctor: _____ Phone: _____

Date of Last Physical Exam: _____ Date of Last Blood Work (if known): _____

Names/Specialties of other providers caring for you:

Name: _____ Specialty: _____

Name: _____ Specialty: _____

Name: _____ Specialty: _____

Medication	Dosage	Frequency

Any **MEDICATION** ALLERGIES? ☐ Yes ☐ No

Name_____ Name: _____ Name: _____

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Compassionate Healthcare of Florida

Please check if applicable:
☐ ADD/ADHD ☐ Anemia ☐ Arthritis ☐ Asthma ☐ Anxiety ☐ Alcoholism ☐ Blood Clots
☐ COPD/Emphysema ☐ Diabetes ☐ Diabetes ☐ Heart Attack ☐ HTN ☐ High Cholesterol
☐ Kidney Disease ☐ Liver Disease ☐ Neurological Disorder ☐ Osteoporosis ☐ Sleep Disorder
☐ Chronic Pain ☐ Other (please list): _____

Please list any medical **PROCEDURES/SURGERIES** you have had in the **past (5) years**:

_____ _____

_____ _____

_____ _____

Social Information

Tobacco Use: Do you smoke? ☐ Current ☐ Former ☐ Never Do you chew? ☐ Yes ☐ No
If yes, how many cigarettes/cigars per day: _____ Number of years: _____

Alcohol Use: Do you drink alcohol? ☐ Yes ☐ No Do you drink daily? ☐ Yes ☐ No
If yes, what type? ☐ Wine ☐ Beer ☐ Liquor How much/week? _____

Drug Use: Any history of illegal drug use? ☐ Yes ☐ No
If yes, what? _____

Have you been convicted of a felony in the **last 2 years**? ☐ Yes ☐ No

Are you currently attending, or have you ever attended any alcohol/substance abuse or rehabilitation programs?
☐ Yes ☐ No If so, when: _____

Do you exercise? ☐ Yes ☐ No Are you on any special diet? ☐ Yes ☐ No
If yes, how often? _____ If yes, what kind? _____

Do you consume any caffeinated products? ☐ Yes ☐ No
If yes, what? ☐ Coffee ☐ Soda ☐ Tea How much/many per day? _____

Have you recently noticed an increase in sadness or gloominess? ☐ Yes ☐ No

Have you lost interest in normally enjoyable activities? ☐ Yes ☐ No

Have you had or do you have any thoughts of wanting to harm yourself or others: ☐ Yes ☐ No

PATIENT SIGNATURE: _____ Date: _____

COMPASSIONATE
HEALTHCARE OF FLORIDA

Compassionate Healthcare of Florida
Medical Records Release

ALL ITEMS ON THIS AUTHORIZATION MUST BE COMPLETED **IN FULL.**

PATIENT NAME: _____

DATE OF BIRTH: _____ PHONE: _____

ADDRESS: _____

_____

RELEASE INFORMATION FROM: (**Provider's** Information Below)	RELEASE INFORMATION TO:
NAME: _____	NAME: Compassionate Healthcare of Florida
ADDRESS: _____	5600 Trail Blvd, Suite 10
_____	Naples, FL 34108
PHONE: _____ FAX: _____	PHONE: 239-431-6739 FAX: 239-207-7921

THE INFORMATION I WISH TO HAVE RELEASED (include dates of service):

_____ History and Physical	_____ Reports of Operation
_____ Imaging Reports	_____ Laboratory Reports
__X__ Notes/Documentation of DX	_____ ALL RECORDS

_____ _____
PATIENT SIGNATURE OR PERSONAL REPRESENATIVE DATE

*IF SIGNATURE IS OTHER THAN PATIENT, PLEASE EXPLAIN YOUR AUTHORITY TO ACT FOR THIS PATIENT BELOW:

_____

_____ _____
WITNESS DATE

COMPASSIONATE
HEALTHCARE OF FLORIDA

Notice of Privacy Practices

I certify that I have been made aware of Compassionate Healthcare of Florida's Notice of Privacy Practices and that I have a right to receive a copy upon request. This Notice describes the type of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills or in the performance of Compassionate Healthcare of Florida's health care operations. The Notice also describes my rights and Compassionate Healthcare of Florida's duties with respect to my protected health information. I understand that copies of the Notice of Privacy Practices are available in the registration areas of each facility. I may request that a copy be mailed to me by calling the office.

Compassionate Healthcare of Florida reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be mailed to me, by asking for one at the time of my next appointment, or by accessing Compassionate Healthcare of Florida's web site at flmmjhealth.com to view the most current version.

_____
SIGNATURE OF PATIENT/REPRESENTATIVE

_____
PRINT NAME OF PATIENT/REPRESENTATIVE

_____
DATE

_____
DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY (if applicable)

PATIENT IDENTIFICATION

Compassionate Healthcare of Florida
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES