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): _____

Florida Home Address:
_____

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

City: _____ Zip: _____ State: _____

Date of Birth: _____

*Social Security Number: _____

Florida Resident Status: □ Full-time □ Seasonal

Age: ____ Sex: □ Male □ Female

Marital Status: □ Married □ Single □ Divorced □ Widowed

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

**This is required by the Florida Medical Marijuana Registry System in order to verify your residency. This is not saved or shared with anyone. Failure to provide this will delay your application.*

Emergency Contact: _____ Relationship to Patient: _____

Phone number: _____

RELEASE OF INFORMATION (If you want to discuss your care with anyone)

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 (If you have one):
_____ 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: _____

Medication	Dosage	Frequency

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

Please list:_____ _____ _____

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Compassionate Healthcare of Florida

Please check if applicable:
☐ ADD/ADHD ☐ Anemia ☐ Arthritis ☐ Anxiety ☐ Asthma ☐ 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 (besides Marijuana)? ☐ 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: _____

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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)