MMJ CERTIFICATION CLINICS
DR. GREEN CERTS

Today's date: _____

PATIENT INTAKE FORM

Filling out this form does not guarantee an approval or recommendation for the use of medicinal cannabis.

Name _____ Date of birth _____ Age _____
(*Print*) First Middle Last

Home Address

_____
Street City State Zip

Mailing Address (if different from Home address)

_____
Street City State Zip

Mobile phone # _____ Other phone # (if no mobile phone) _____

May we leave a phone message? Yes _____ No _____ May we contact you by text? Yes _____ No _____

Email _____ May we contact you by email? Yes _____ No _____

Job title/ Occupation _____

How did you hear about us? _____

Yes _____ No _____ Did you bring in any coupons or discounts today?

Yes _____ No _____ Do you receive **Supplemental Nutritional Assistance (SNAP/ Food Stamps/ EBT)**?

Current Medical Complaint(s) that qualify you for a Medical Marijuana card:
1) _____ 2) _____ 3) _____

Yes _____ No _____ Are you currently under the care of a physician?
If yes, what is the name of your primary care physician or the medical facility?
_____

Yes _____ No _____ Did you bring medical records today from within the past 12 months?
If Yes, please give your records to the front desk prior to filling out the rest of this form.

Yes _____ No _____ Have you been evaluated for the use of medical marijuana by any other physician in the past?
If yes, please give name of doctor or clinic, approximate date seen and condition approved for:
_____ **Check here if your card is expired [ ]

Yes _____ No _____ Have you been evaluated and denied a medical marijuana recommendation?
If yes, please explain: _____

Yes _____ No _____ Do you currently smoke tobacco? If yes, for how many **years**? _____

Yes _____ No _____ Do you currently use marijuana? If yes, **how much** do you use per week? _____

Yes _____ No _____ Are you taking any medications? If yes name the medication(s) and dosages:
1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

Yes _____ No _____ Do you have any allergies to medications? If yes, please list medicine(s):
1) _____ 2) _____ 3) _____

Yes _____ No _____ Have you had any X-rays/ Ultrasounds/ MRIs/ CAT scans done within the past 1 year?
If yes, **please list below.** Also, **let the front desk know if you have the medical reports with you.**

_____

Yes _____ No _____ Have you ever had surgery or been hospitalized? If yes, **give dates** and **details**:

1) _____ 3) _____

2) _____ 4) _____

In your own words, please describe how your condition limits you or decreases your quality of life:

_____

_____

_____

Females Only:
Yes _____ No _____ Are you pregnant or planning a pregnancy?
Yes _____ No _____ Are you breastfeeding? **If yes to either of these questions, please let the front desk know.**

Please indicate if you have any of the following health issues:

[ ] AIDS	**[ ]** PTSD	**[ ]** Kidney disease	**[ ]** Asthma
[ ] HIV	**[ ]** Seizures	**[ ]** Heart disease	**[ ]** COPD
[ ] ALS	**[ ]** Headaches	**[ ]** Stroke	**[ ]** Fibromyalgia
[ ] Glaucoma	**[ ]** Migraine	**[ ]** Hypertension	**[ ]** Chronic fatigue syndrome
[ ] Hepatitis C	**[ ]** GERD/ heart burn	**[ ]** Anxiety	**[ ]** Difficulty sleeping
[ ] Substance abuse	**[ ]** IBS	**[ ]** Depression	**[ ]** Muscle spasms
[ ] Alzheimer's disease	**[ ]** Crohn's disease	**[ ]** Schizophrenia	**[ ]** Gout

[ ] Cancer - what type? _____ **[ ]** Thyroid (hypothyroid – underactive)

[ ] Diabetes - what kind? _____ **[ ]** Thyroid (hyperthyroid – overactive)

[ ] Chronic Pain – please list **specific body locations** and **cause(s) of pain**:

_____

_____

_____

Tell us about any other medical conditions you have that are not listed above or checkmark here: [ ] None

_____

List any health problems that occur frequently in your family (i.e. Father-Cancer, Brother-Diabetes):

_____

_____

I hereby declare that I have completely and truthfully disclosed all information regarding my medical condition and attest that I am not a member, employee or agent of any media or law enforcement agency. It is illegal for a patient to film or record in this office with video camera, cell phone or any other recording device whether still image, video or audio. This is a direct violation of HIPAA regulations and patient/doctor confidentiality.

I acknowledge that it is up to me to become a patient of Dr. Green Certs and I am in no way being coerced to do so.

I am aware that my approval or recommendation may be revoked at any time if I have perjured or misrepresented myself or my condition.

I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT.

Patient Signature _____ Date _____

Informed Consent: Risks and Side-Effects, Release of Liability

Patient Initials	***Please read ALL information carefully and initial in box to the left of each section***
____	I acknowledge I am responsible to know the Arizona State laws regarding legal acquisition and use of medical marijuana information available to me on the AZDHS.gov website. I understand that I must be an Arizona State resident to obtain an approval or recommendation for the use of cannabis.
____	I affirm that I have a serious medical condition that adversely affects my quality of life. I agree to provide the physician with any and all copies of my MEDICAL RECORDS, if they exist, that document my medical conditions, as requested by the physician.
____	I am seeking a recommendation for my own, personal, medical use. I DO NOT plan or intend to use my physician's recommendation for the purpose of illegally obtaining medical cannabis.
____	**Safety & Effectiveness** • I am aware that a Notice of Compliance has not been issued under the Food and Drug Administration (FDA) concerning the safety and effectiveness of the medical use of marijuana as a drug. I understand the significance of this fact. • I understand that cannabis can adversely affect my health. SIDE-EFFECTS associated with medical marijuana use may include: dry mouth, nausea, headache, tremor, nystagmus, rapid heart rate, reduced muscle strength, decreased brain blood flow, decreased coordination, lung irritation, increased weight gain, altered body temperature, anxiety, paranoia, confusion, aggressiveness, hallucinations, suicidal thoughts, sedation, altered libido, altered perceptions, addictive behavior, reduced testicular size and testosterone, menstrual abnormalities, infertility, abnormal ova, and fetal exposure in pregnancy. • There is a possibility that cannabis may worsen schizophrenia in persons predisposed to the disorder. • Should I experience any negative side-effects that may be caused from my therapeutic use of cannabis or feel that cannabis use is adversely affecting my health, I agree to stop using it. I will schedule an appointment to be further evaluated by my primary physician to determine another form of treatment to address health concerns. I understand that it is my responsibility to contact a Hospital Emergency Department for any medical emergencies. • There is the possibility of experiencing withdrawal symptoms when I stop using cannabis. I understand that these withdrawal symptoms can include, but are not limited to, depression, irritability, insomnia, loss of appetite, and tiredness. • I have discussed and have been informed by the medical practitioner of the potential benefits and risks of using cannabis. • I understand that the benefits and risks associated with the use of marijuana are not fully understood and that the use of marijuana **may involve risks** that have not been identified. There are no claims about the medical efficacy of cannabis. • I affirm that I fully understand the potential risks and side effects related to the use of cannabis as described above. Furthermore, in using cannabis therapeutically, I accept full responsibility in assuming the risks and side effects related to its use.
____	I agree not to drive a car or operate dangerous or heavy machinery while using marijuana.
____	I understand that cannabis is not recommended while under the influence of alcohol.
____	This clinic, its staff and representatives are addressing specific aspects of my medical care and are in no way establishing themselves as my primary care provider. I agree to continue follow-ups with my primary care physician's office, or obtain a primary care physician if I have none now. I understand this is an obligation on MY part as continuity of care.
____	Based on my belief and general information that I have obtained from different sources, which includes researching scientific literature about the established benefits and risks of using cannabis to treat my medical problems, I request the doctor to EVALUATE me for a possible recommendation for medicinal use of marijuana which would enable me to legally obtain cannabis.

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Patient Initials	
_____	Neither Dr. Green Certs Clinics nor anyone acting on Dr. Green Certs Clinics' behalf has made any representation to me about the application or enforcement of state or federal law in connection with the possession or use of medicinal marijuana.
_____	I agree that the attending physician and his/her principals, agents, and employees, shall not be held responsible for any harm resulting to me and/or other individuals as a result of my medicinal use of cannabis.
_____	I understand that my State of Arizona medical marijuana certification must be renewed before the expiration date in order to be considered a renewal patient next year.
_____	If I do not wish to upload my application to the Arizona Department of Health Services (AZDHS) today, with the help of Dr. Green Certs Clinics, then I will have 90 days from the date of being issued a signed physician certification form to apply to the state for a legal medical marijuana card. If I miss the 90 day application window, I acknowledge that I will be required to be re-evaluated by a physician and pay whatever fees are required for re-evaluation.
_____	• I am not currently part of a child custody, medical or disability dispute. I clearly understand that marijuana usage under any of these situations is not recommended by our office until after dispute resolution. • The evaluation that I receive today is not to be utilized in any manner for support of a disability claim, Workman's Compensation claim, or life insurance, or other insurance application or claim. I will consult a dedicated physician for this if I am in need.
_____	I am not currently in any drug or alcohol rehab program.
_____	I am not a student in high school.
_____	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, without my consent or unless required by law. I acknowledge that I have received Dr. Green Certs Clinics' Notice of Privacy Practices.
_____	Request for Medical Records: Our office follows HIPAA's regulations for processing the release of medical records at all times. A signature form is required to process any requests for the release of records. Records being forwarded to a medical facility for concurrent medical care are not assessed a fee. Personal requests for copies of medical records are assessed a fee of $50.00 for a complete chart. Records will be sent by USPS Priority Mail to the home address on record, unless otherwise requested in writing, and postage fees may be applied. Patient is responsible for total fees prior to processing records. Records are processed weekly, however; additional time may be required if the records are archived or abnormally large. Policies and procedures may be altered at any time and will be posted within the office as notification.

I CLEARLY UNDERSTAND THAT NEITHER THIS OFFICE NOR THE DOCTOR CONDONES ANY ILLEGAL ACTIVITY WITH REGARDS TO MEDICAL MARIJUANA USAGE. ANY IMPROPER USE WILL LEAD TO THE REVOCATION OF MY MEDICAL RECOMMENDATION.

I certify that all information I have provided in this 'patient intake form' is true and correct.
I certify that all information verbally transmitted to the office staff and doctor(s) is true and correct.
I certify that I have carefully read all the above with full understanding and agreement.

Furthermore, the undersigned, my heirs, assigns, or anyone acting on my behalf, hold the physician, the principals, agents and employees, free and **harmless of any liability** resulting from the use of cannabis.

Patient Name (please print) _____

Patient Signature _____ Date _____

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

MARIJUANA PROGRAM PATIENT ATTESTATION

I, _____ , attest that:

I will not divert marijuana to any individual who or entity that is not allowed to possess marijuana pursuant A.R.S. Title 36, Chapter 28.1 and that the information provided in the application is true and correct.

_____ _____

Signature Date Signed