Genesis Healthcare Associates

Please Print or Type

CANNABIS EVALUATION REGISTRATION FORM

PATIENT NAME:	FIRST	MIDDLE	SOCIAL SECUTIRY NUMBER	DATE OF BIRTH	SEX
MAIDEN NAME:	FIRST	MIDDLE	EMPLOYER	MARTIAL STATUS	
STREET			OCCUPATION		
CITY	STATE	ZIP	EMPLOYER ADDRESS	CITY	
HOME PHONE	CELL		PHONE	STATE	ZIP
E-MAIL ADDRESS			DRIVER'S LICENSE #		

PERSON RESPONSIBLE FOR BILL (OMIT IF SAME AS PATIENT INFORMATION)

I-AST NAME:	FIRST	MIDDLE	RELATIONSHIP SOCIAL SECUTIRY NUMBER		DOB
STREET			EMPLOYER	OCCUPATION	
CITY	STATE	ZIP	STREET	CITY	
HOME PHONE	BUSINESS/DAY TIME PHONE		CITY	COUNTY	ZIP

EMERGENCY CONTACT - IF RESIDING AT A DIFFERENT ADDRESS (e.g. Friend or Relative)

	FIRST	MIDDLE	RELATIONSHIP
STREET			HOME PHONE
CITY	STATE	ZIP	BUSINESS/DAY TIME PHONE

Policies & Disclosures

These services are not covered by insurance; therefore, payment in full is required at the time of service and is Non-Refundable. Failure to pay will result in your appointment being cancelled and/or rescheduled. We accept Cash, Mastercard, Visa and American Express. Checks are not accepted.

Missed appointments: There will be a $25.00 fee accessed to your account for appointments not cancelled 24 hours in advanced of your appointment time. After two missed appointments, we reserve the right to refuse treatment.

You will receive a physical exam and review of your history. This does not automatically guarantee that you will be approved for a Cannabis Card. A physical exam and review of history is required by law every year for renewals.

Consent for Treatment: I give my consent to Genesis Healthcare Associates and the staff to perform physical evaluations and testing which are appropriate for my condition(s) or illnesses that will help to access my need for Cannabis use.

Signature: _____ Date:_____

Parent or Legal Guardian signature_____ Date:_____