Dr. Cannabis Compassionate Clinic and Wellness Center

REGISTRATION FORM

Today's Date:	PCP:

PATIENT INFORMATION

Patient's last name:	**First:**	**Middle:**	**Marital status:**

Is this your legal name?	**If not, what is your legal name?**	**Weight:**	**Birth date:**	**Age:**	**Sex:**
○ Yes ○ No					○ M ○ F

Address:

County of Legal Residence:

Social Security Number:	**Home Phone:**	**Cell Phone:**

Email Address:

How did you hear about our clinic/
Name of person referred by:

Other family members seen here:

CAREGIVER INFORMATION (USE ONLY IF REGISTERING A CAREGIVER WITH THE STATE OF FLORIDA)

Last Name: First Name: DOB:

Address: Phone Number:

Email Address:

County of residence: Social Security Number:

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I understand that I am financially responsible for any payment due at time of service.

Parent/ Guardian Signature: **Date:**