Cannabis MD

REGISTRATION FORM

Today's Date:	PCP:

PATIENT INFORMATION

Last name:	First:	Middle Initial:	Marital status:

Other Language Preferences: ○ Yes ○ No	Social Security: If Selected Yes, Which Language:	Birth date:	Age:	Sex: ○ M ○ F

Street Address:		
City: State:	Home phone no.: Is it okay to leave messages?	Cell phone no.: Is it okay to leave messages?
Zip Code: Occupation:	Employment Status: Employer:	Email: Employer phone no.:

Referred to clinic by: ○ Doctor ○ Attorney: Other:

Doctor's Name:

Attorney's Name:

INSURANCE INFORMATION

(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST.)

Please indicate primary insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment:

Patient's relationship to subscriber:

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Cannabis MD or insurance company to release any information required to process my claims.

Patient/Guardian signature: Date: