Once form is completed, please email to your preferred location: **CALGARY** staff@420clinic.ca *OR* **LETHBRIDGE** lethbridge@420clinic.ca

Office: (403) 475-4205
Fax: (403) 475-4208
Email: staff@420clinic.ca

REGISTRATION FORM

Patient completes sections A and B

Today's Date_____ /_____ /_____ Your Preferred Appointment Date _____ /_____ /_____ and time____:____

SECTION A: PERSONAL INFORMATION

Patient's Last Name	First	Middle

Street Address	City	Province	Postal Code

Home Phone ( ) -	Work Phone ( ) -	Cell Phone ( ) -	Email Address

D.O.B. (mm/dd/yyyy) / /	Age	Allergies ☐ No ☐ Yes ______	Gender ☐ M ☐ F

Occupation	Employer

SECTION B: PHYSICIAN INFORMATION

Medical Doctor's Name	Phone ( ) - Fax ( ) -

Medical Doctor's Street Address	City	Province	Postal Code

SECTION C: MEDICAL INFORMATION (FOR OFFICE ONLY)

Chief Medical Condition	Symptoms

Current Medications (with dosage)

Past Medical History	Have you tried any other conventional treatments for your conditions? If Yes, please detail (e.g. Medication, surgery, massage, acupuncture, etc.) Since beginning treatments your symptoms have: ☐ Improved ☐ Worsened ☐ No Change

Have you used Cannabis before? ☐ Yes ☐ No If Yes, for how many years?________________ Amount: ______grams/d

Administration: ☐ Smoked ☐ Orally ☐ Other Any adverse effects from cannabis use?________________

Since using cannabis, your symptoms have ☐ Improved ☐ Worsened ☐ No Change

Any personal or family history or Schizophrenia or Psychosis? ☐ Yes ☐ No If yes, please detail ________________

History of substance abuse or dependency? ☐ Yes ☐ No If yes, please detail ________________

HOW DID YOU HEAR ABOUT US?

☐ Doctor ☐ Website ☐ Family ☐ Friend

☐ Other ________________

RECOMMENDED DOSAGE (FOR OFFICE USE ONLY)

Grams: ______________ (g) Duration of Use: ____________

Additional Notes: ________________

____

____

____

________________ Intake Recorded By ______ Initial

SECTION D: AGREEMENT

I agree that above information is true to the best of my knowledge.

420 Clinic is not responsible for any misuse of medical cannabis. Misuse or transfer is subject to law enforcement and penalty. I understand that I could/will lose my medical document for any reason deemed necessary by 420 Clinic for misuse or infraction.

I consent to receive email communications from 420 Clinic.

☐ Yes, I agree to receive emails.
☐ No thanks.

________________ Patient Name (Please Print) ________ Date

________________ Patient Signature