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

420 CLINIC +

Office: (403) 475-4205
Lethbridge: (403) 327-4687
Fax: (403) 475-4208
Email: staff@420clinic.ca

CLEAR FORM

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