365 West Patrick Street, Suite 202 Frederick, MD 21701
(O): 301.682.2047 (F): 240.815.6905

Date:					
Patient's Last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no: ( )

Primary Care Provider:

INSURANCE INFORMATION			
(Please give your insurance card to the receptionist.)			
Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: (
Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

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: ❑ Self ❑ Spouse ❑ Child ❑ Other

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

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

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 authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance.

Patient/Guardian signature *Date*

365 West Patrick Street, Suite 202 Frederick, MD 21701
(O): 301.682.2047 (F): 240.815.6905

COORDINATION OF CARE RELEASE

PATIENT INFORMATION (PLEASE PRINT)

Patient Name: ____

Date of Birth: ________________________ Telephone # ____

Address: ____

RELEASE INFORMATION TO & FROM:

Pharmacy Name _______________________________________Phone # ___________________________

Primary Doctor _______________________________________ Phone # ___________________________

Specialist: ____ Phone # ___________________________

Lawyer: ____ Phone # ___________________________

Other:____ Phone #: _____________________________

INFORMATION TO BE RELEASED (CHECK ALL THAT APPLY)

- ☐ Clinic Visit Notes
- ☐ Complete Chart
- ☐ Discharge Summary
- ☐ Imaging Reports
- ☐ Lab Reports
- ☐ Operative Reports
- ☐ Pathology Reports
- ☐ Pharmacy Reports
- ☐ Other: _______________________

Patient Signature: _______________________________ Date: __________________________________

AUTHORIZATION FOR RELEASE OF SENSITIVE INFORMATION

This medical record may contain certain sensitive or statutorily protected information. Please indicate the information you would like released. A separate signature is required.

- ☐ Mental Health Information
- ☐ Domestic Violence Information
- ☐ Alcohol/Drug Abuse Information
- ☐ Social Service Information
- ☐ Sexual Assault Information
- ☐ Sexually Transmitted Diseases

Patient Signature: ____________________________________Date: ______________________

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Revive and Thrive Mental Wellness.

I also understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and no longer protected by federal laws and regulations regarding the privacy of my protected health information. I certify that I have received a copy of this authorization.

Patient Signature: ___________________________________ Witness: ______________________________
Date:__________________

365 West Patrick Street, Suite 202 Frederick, MD 21701
(O): 301.682.2047 (F): 240.815.6905

Medical History

(Provide Yes or No to Every Question)

Consume Alcohol? □ Yes □ No # of drinks per week____________

Smoke/Chew Tobacco? □ Yes □No # of cigs per week____________ Qty of chew per week_________

Any form of regular exercise? □Yes □No # of times per week ___________________

What is the exercise? ____

Are you currently taking any medications on a regular basis? Check those that apply

Prescription Medications? □ Yes □ No OTC Medications? □ Yes □ No

Herbal Medications? □ Yes □ No Vitamins or Minerals? □ Yes □ No

Please list all medications:

*____

*____

*____

*____

*____

Any allergies to medications? □ Yes □ No (If yes please list below)

Name of medication/Type of reaction____

Allergies to any food products □ Yes □ No (if so please list below)

Allergy/Type of reaction____

365 West Patrick Street, Suite 202 Frederick, MD 21701
(O): 301.682.2047 (F): 240.815.6905

Medical Symptoms/Diagnosis

Reason (s) for Evaluation

Diagnosis made by a healthcare provider: (make an X in front of the disease(s))

□ Aids/HIV □ ADHD □ Asthma □ COPD □ Disabled permanently □ Diabetes w/ extremity pain or nausea

□ Glaucoma □ Heart Disease □ High Blood Pressure □ Stroke □ Kidney Disease □ Muscle or Movement Disease

□ Bipolar □ Schizophrenia □ Depression □ Migraine Headaches □ Stomach Ulcers □ Epilepsy/Seizures □ ALS

□ Hepatitis B or C □ Multiple Sclerosis/CP □ Parkinson's Disease

Symptoms you have experienced:

(make an X in front of the symptoms)

□ Anxiety/Stress

□ Headaches

□ Dizziness/Vision problems

□ Acid reflux? Heartburn/ Stomach Pain

□ Loss of appetite/Weight gain

□ Constipation

□ Skin Rashes

□ Depressed Feelings

□ Numbness or Tingling in limbs

□ Insomnia/Sleep disorders

□ Nausea/Vomiting

□ Urinary Problems

□ Chronic Pain, where? ____

□ Muscle Spasms, where? ____

□ Other: ____

365 West Patrick Street, Suite 202 Frederick, MD 21701
(O): 301.682.2047 (F): 240.815.6905

Main problem?

____

What caused your problem?

____

How long have you had these symptoms?

____

Frequency of symptoms?

____

Intensity of symptoms? Rate 1-10

____

All treatments for this problem

____

365 West Patrick Street, Suite 202 Frederick, MD 21701
(O): 301.682.2047 (F): 240.815.6905

Family Medical History (if Known)

Parents:

Diagnosed Conditions:

□ High Blood Pressure □ Diabetes □ Cancer □ Cohn's Disease □Alzheimer's Disease

□Multiple Sclerosis □ Rheumatoid Arthritis □ Stroke □ Heart Disease

□ Other____

Siblings:

Diagnosed Conditions:

□ High Blood Pressure □ Diabetes □ Cancer □ Cohn's Disease □Alzheimer's Disease

□Multiple Sclerosis □ Rheumatoid Arthritis □ Stroke □ Heart Disease

□ Other____

Grandparents:

Diagnosed Conditions:

□ High Blood Pressure □ Diabetes □ Cancer □ Cohn's Disease □Alzheimer's Disease

□Multiple Sclerosis □ Rheumatoid Arthritis □ Stroke □ Heart Disease

□ Other____

Prior Cannabis usage: (Fill out if applicable)

Have you ever used marijuana in a recreational form? □ Yes □ No

Have you ever used medical marijuana? □ Yes □ No

Indicate what forms of administration used:

□ Inhale(Combusted) □ Inhaled(Vaporized) □ Edible □ Topical

□ Other ____

(Any information shared is confidential and will not be shared without your consent)

365 West Patrick Street, Suite 202 Frederick, MD 21701
(O): 301.682.2047 (F): 240.815.6905

Physician Information:

Name: ____

Phone: ____

Fax: ____

Street address: ____

City, State, Zip: ____

Other Doctors? (if so please give info)

Name: ____

Phone: ____

Fax: ____

Street address: ____

City, State, Zip: ____

365 West Patrick Street, Suite 202 Frederick, MD 21701
(O): 301.682.2047 (F): 240.815.6905

Disclosure and Conditions:

1. ______ I understand if I do not have verified diagnosis prior to coming to Revive and Thrive Mental Wellness I may not be granted my medical marijuana recommendation.

2. ______ I acknowledge that if I am found guilty of any distribution charge my medical marijuana recommendation will be revoked.

3. ______ I understand that if I do not comply with my medical marijuana contract my recommendation can be revoked.

4. ______ I understand that services rendered at Revive and Thrive Mental Wellness is strictly for the purposes of obtaining a recommendation for medical marijuana.

5. ______ I will not divert or provide medical cannabis to anyone.

6. ______ I affirm that I have a qualified medical condition which may adversely affect my quality of life.

7. ______ I have found, or I am interested in determining whether cannabis (medical marijuana) provides relief and improvement of my condition (s) or symptom (s) of my conditions (s).

8. ______ I have discussed and have been informed by a healthcare provider of the potential benefits and risks of using cannabis.

9. ______ I have been assured that medical records relating to my care will be kept private and confidential and that no information will be released or printed unless a signed release is obtained.

10. ______ I am aware that a notice of compliance has not been issued under the Food and Drug regulations (FDA). Concerning the safety and effectiveness of the medical use of marijuana as a drug. I understand that marijuana is still considered a scheduled I drug under federal regulations.

365 West Patrick Street, Suite 202 Frederick, MD 21701
(O): 301.682.2047 (F): 240.815.6905

Disclosure and Conditions:

Proper use and follow up

1. ______I have been notified by this office and agree the use of cannabis may ADVERSELY affect my health. If this occurs, I will STOP using cannabis and will schedule a follow up appointment to be further evaluated by a physician to determine another form of treatment. I assume all risks for usage.

2. ______ I agree NOT TO DRIVE a car or OPERATE DANGEROUS or HEAVY EQUIPMENT while using marijuana.

3. _______ I understand that I am required to return annually for a new recommendation

4. _______I understand that side effects associated with medical marijuana may include the following:
   - Dry mouth
   - Nausea
   - Headache
   - Tremors
   - Rapid heart rate
   - Reduced muscle strength
   - Decreased brain blood flow
   - Decreased coordination
   - Lung irritation
   - Increased weight gain
   - Altered body temperature
   - Anxiety/Paranoia/Confusion/Aggressiveness/Hallucinations
   - Suicidal thoughts
   - Altered libido
   - Altered perceptions
   - Addictive behavior
   - Reduced testicular size and testosterone, Menstrual abnormalities, Infertility.

MMCC #_________________________________
Patients Signature: _______________________________________
Date: ____
Witness: ____