Medical Marijuana Intake Form

Legal Name:____ ______________
Last First MI Preferred Name

Email Address: _________________________________ SSN: ____-___-________

Address: ____

City: _____________________________ State: ________ Zip: _____________

Date of Birth: _________ Height: _____ Weight: _____ Gender: □ Male □ Female

□ I am a Permanent Resident of Florida or □ I am a Seasonal Resident of Florida

I will require a Caregiver to help me with my Medical Marijuana: □ Yes □ No

□ I authorize Pain Plus & OMMU to communicate with me via email and/or text.

Preferred Phone : (___) ____-_________ Secondary Phone : (___) ____-___________

Do you currently take or have a prescription for Opioid Pain Medicine? □ Yes □ No

How often to you utilized marijuana?
□ Never before □ Distant Past □ Occasionally □ Regularly

Marital Status: □ Married □ Single □ Divorced □ Separated □ Widowed □ NA

Work Status: □ Employed □ Student □ Retired □ Unemployed □ Disabled

Employer/School name ____

Referral Source: _______________Primary Care Physician:__________________

In Case of Emergency, Contact:

Name: _______________ Relationship: ____________Phone: ______________

ADDITIONAL INFORMATION:

Signature: __________________________________ Date: _________________

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