PATIENT INTAKE FORM

Date: _____

Patient: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: _____ Alternate Phone: _____ Social Security Number: _____

E-mail address: _____

In case of emergency: _____ Relationship: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Pharmacy: _____ Location: _____ Phone: _____

Primary Care Provider: _____ Phone: _____

MEDICAL HISTORY:

Hospitalizations ~ Date and illness/Reason: _____

Surgeries ~ Date and Type (including any body implants such as cardiac stents, heart valves, joint replacements, pacemakers:

Ongoing Medical Problems ~ including asthma, COPD, diabetes, heart disease, heart murmur, hepatitis, HIV/AIDS, hypertension, kidney failure, venereal disease, alcohol or drug addictions, present or previous psychiatric care: _____

Allergies ~ Name of Drug and Reaction, including any type of anesthetic: _____

CLINICAL HISTORY AND CONDITION:

Indication for Cannabis Treatment: _____

Chief complaint for evaluation of cannabis treatment: _____

List of Symptoms ~ Type / Frequency / Severity

1. _____
2. _____
3. _____

Prior Treatment(s), Duration and Outcome of Treatment: _____

RX Medication Name	Dosage	Regimen	Target Symptom

OTC / Vitamins / Supplements / Herbals / Homeopathic / Other Self-Medications

Medication Name	Dosage	Regimen	Target Symptom

Are you currently taking Aspirin, Coumadin, Plavix, Persantine or other blood thinners?

Preventative care - list ongoing medical treatments, special diets, physical therapies, etc.

If female, are you currently pregnant or think that you may be: YES ☐ NO ☐

Date of last menstrual cycle _____

Are you planning on getting pregnant? YES ☐ NO ☐

FAMILY MEDICAL HISTORY:

Hereditary diseases, significant illnesses or cause of death of grandparents / parents / children / siblings / aunts / uncles / cousins, Example: allergy / bleeding disorders / cancer / heart disease / sickle cell anemia / psychiatric problems such as anxiety/ bi-polar / depression, etc.

NUTRITIONAL HISTORY:

Special dietary needs:

SOCIAL HISTORY AND HABITS:

Coffee _____ cups / day Tea _____ cups / day

Alcohol _____ cups / day Tobacco _____ cigarettes / day

How many years have you been smoking? _____ If you quit, when did you stop? _____

Do you currently use marijuana? YES ☐ NO ☐

If yes, how often and by what method, does it help alleviate symptoms of your qualifying condition?

Recreational drug use - frequency / type / route, ie. Ingestion, injection, snorting

MEDICAL MARIJUANA PATIENT DECLARATION

I hereby declare that I have completely and truthfully disclosed all information regarding my medical condition and attest that I do not intend to use my medical recommendation for the purpose of illegally obtaining, growing or distributing medical marijuana.

I attest that I am not a member, employee or agent of any media or law enforcement agency. It is illegal to film or record in this office with a video camera, cell phone or any other recording devise be it a still image, video or audio, this is a direct violation of HIPAA regulations and patient/doctor confidentiality.

I am aware that my recommendation can be revoked at any time and legal actions will be taken if I have perjured or misrepresented myself or my condition, my intentions or falsified any medical records to the physician. I also hereby authorize Henry Calas MD, PA or its representative, to discuss my medical condition for verification purposes only.

Additionally, I acknowledge the attending physician informed me of the nature of a recommended treatment, including but not limited to, any recommendation regarding medical marijuana. The risks, complications and expected benefits of any recommended treatment, including its likelihood of success or failure.

I acknowledge the attending physician informed me of any alternatives to the recommended treatment, including the alternative of no treatment, and their risks and benefits. The physician may request that I visit another physician or specialist to further substantiate my condition. I will be informed of all the above-mentioned regardless of whether or not I qualify as a patient.

PATIENT NAME (PRINT) _____

Telephone Number _____ **Alternate Telephone Number** _____

Current Address _____

City _____ **State** _____ **Zip code** _____

PATIENT SIGNATURE _____

RELEASE OF LIABILITY

I attest that the information on this form is correct and any medical history presented or discussed with the doctor is all factual and complete to the best of my knowledge. I do not plan or intend to use my Physician's recommendation for the purpose of illegally obtaining medical marijuana. Solely for verification purposes, I authorize Dr. Henry Calas to converse regarding my medical condition.

I understand that I must be a **Florida** resident to obtain an approval or recommendation for the use of medical cannabis.

I affirm that I have a serious medical condition that negatively affects my quality of life. I have found or am interested in finding out whether or not medical marijuana provides substantial relief and improvement in my condition.

I understand that the cannabis plant is not regulated by the United States Food and Drug Administration and therefore may contain unknown quantities of active ingredients, impurities and /or contaminants. I understand the potential risks associated with an elevated daily consumption of medical marijuana including risks with respect to the effect on my cardiovascular and pulmonary systems and psychomotor performance, risks associated with the long-term use of marijuana are not fully understood and that the use of marijuana may involve risks that have not been identified. In requesting an approval or recommendation for the use of medical marijuana, I assume full responsibility for any and all risks involved in this action.

I have been advised that medical marijuana smoke contains chemicals known as tars that may be harmful to my health. Recent research indicates that vaporizing cannabis may eliminate exposure to tar. Should respiratory problems or other ill effects be experienced in association with its use, it should be discontinued and reported to the physician immediately.

I was also advised that the use of medical marijuana might affect my coordination and cognition in ways that could impair my ability to drive, operate machinery, or engage in potentially hazardous activities. I assume full responsibility for any harm resulting to me and/or other individuals as a result of my use of cannabis.

Florida's Medical Marijuana Legalization Initiative - Amendment 2, approved November 8, 2016

Provides for the possession of medical marijuana for the personal medical purposes of the patient with a physician approval or recommendation. It should be made clear that the physician, staff and representative of this practice are not providing medical marijuana, nor are they encouraging any illegal activity in my obtaining medical marijuana.

I, the undersigned, hereby request a consultation by the physician for the purposes of determining the appropriateness of medicinal marijuana treatment. I acknowledge that using cannabis as a medicine has been explained to me and that any questions that I have asked have been answered to my complete satisfaction. The physician, staff and representatives are addressing specific aspects of my medical care, and unless otherwise stated are in no way establishing themselves as primary care provider. Should an approval be made for my medicinal use of marijuana, I understand that there is a renewal date specified by the physician depending on the condition. I understand that it is my responsibility to see the physician to assess the possible continuance of cannabis use beyond the term of the approval.

Furthermore, the undersigned, or anyone acting on my behalf, hold the physician and his/her principals, agents and employees, free of and harmless from any liability resulting from the use of medical marijuana.

I further understand that by signing below, I am authorizing the release of any part of this record, except for identifying information, for use in data analysis of medical marijuana treated patients.

PATIENT NAME: _____ **DATE:** _____

PATIENT SIGNATURE: _____

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

AUTHORIZATION FOR USE/DISCLOSE OF PHI (Protected Health Information)

Patient Name: _____ **Date of Birth:** _____

Acknowledgement of Privacy Notice

I have received the practice's Notice of Privacy Practices. The Notice provides in detail the uses and disclosures of my PHI (Protected Health Information) that may be made by this practice. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all PHI at, or controlled by, this practice. I understand I can obtain this practice's Notice of Privacy on request.

Authorization for Use/Disclosure of Protected Health Information (PHI)

I authorize the use and disclosure of all health information for the purpose of treatment, payment and Health Care Operations. I authorize Dr Henry Calas and his staff to use these disclosures of my health information without limitation. I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected. I understand that any revocation does not apply to disclosures or use of PHI that have occurred prior to my revocation. In addition, I authorize disclosure of my PHI to the following individual(s):

_____

_____

_____

List any person(s) that you are allowing this office to communicate with regarding your PHI

Patient Manner of Contact

In general the HIPAA Privacy rule gives individuals the right to request a restriction on uses and disclosures of their PHI. I understand that verbal request is an acceptable authorization for the use of any alternate contact method, number and/or location as well as to change in the manner listed below (i.e. if patient leaves message with contact number and/or location, other than listed below). I understand that this practice calls to confirm appointments at the number I give.

**** I wish to be contacted in the following manner:**

_____ NO RESTRICTION (okay to contact home and/or work and leave detailed message)

_____ Restricted method of contact:

_____ Home ONLY - Message to return call to doctor's office

_____ Work ONLY - Message to return call to doctor's office

_____ Other _____

I understand that by signing this form I am confirming my receipt of the Notice of Privacy Practices; authorization for method of contact; and authorization for use and/or disclosure of my PHI.

Signature _____ **Date** _____

Relationship to patient, if signed by a personal representative, i.e. parent, legal guardian, etc.:

Relationship _____

Signature _____ **Date** _____