Office Use Only! MAIL _____ ONLINE _____ Emailed? _____ PC-20_____ - _____

OV _____ Pkg _____ IPC_____ CC/Not _____ Other _____ Total Pd _____ By _____

Healthy Choices Unlimited

Patient Registration Form

Last Name	First Name Middle Init.
Patient Social Security # (Required by State of CO)	Birth date / / Age Gender Mo Day Yr M ❑ F ❑
Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Other	Name of parent or guardian, if applicable
Home phone #	Cell Phone #
Email Address	
Mailing Address	
City	***County*** ZIP Code
Preferred appointment / clinic communications: ❑ Email ❑ Cell phone ❑ Text ❑ Home phone ❑ US Mail	
Occupation	Employer *We ask only for care purposes, since your work affects your health.*
Do you have Health Insurance? ❑ Yes (Please name Company) ❑ No *Our clinic does NOT bill insurance for medical cannabis evaluations. We do NOT report any information to your insurance company. We ask for in-office care information only. Should you wish to file insurance / HSA claims yourself, ask us for an itemized bill.*	
How did you hear about us? ❑ Returning Patient ❑ Family/Friend ❑ Craig's List ❑ Internet /Website ❑ Westword ❑ Newspaper/Magazine ❑ Dispensary or Store name:	

About Today's Visit

Visit Type: ❑ New Patient ❑ Renewal ❑ Change Plant Count /Homebound Status ❑ Consult only -*go to next section*	
How will you apply to the CO Medical Marijuana Registry? ❑ Apply and receive via US Mail ❑ Apply Online / print yourself	Who will grow your medicine? ❑ Myself ❑ I Don't Know ❑ Caregiver name: ❑ Dispensary name:
Are you Homebound? (unable to go out alone) ❑ Yes ❑ No	Are you requesting extra plants today? ❑ Yes ❑ No

Emergency Contact Information

Local Friend or Relative: Phone #

Relationship to you:

Certification / Attestation

1. The above information is true and correct to the best of my knowledge. 2. I understand that I am financially responsible for any balance due.
3. I am at least the age of 18 and I am not currently pregnant. Or I am the parent or guardian of the patient, who is not pregnant to my knowledge.
4. I have reviewed and agree to the Notice of Privacy Practices on the back of this form or posted in the office.
5. I authorize use/release of my health information as required by Healthy Choices Unlimited to provide me with medical care and to assist with my State Medical Marijuana Registry application.

Signature	*Date*

Notice of Privacy Practices

This notice describes how personal medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you would like a copy of this notice, please ask and we will give you one.

1. Our pledge regarding medical information

The privacy of your medical information is important both to you and to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. Our legal duty

The law requires us to

- Keep your medical information private;
- Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information;
- Follow the terms of the current notice.

We Have the right to

- Change our privacy practices and the terms of this notice at any time, provided the changes are permitted by law;
- Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of change to privacy practices

- Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. Use and disclosure of your medical information

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed.

We will not use or disclose your medical information for any purpose other than treatment, assistance applying to the Colorado Medical Marijuana Registry, payment, and reminders – without your specific written authorization. Any specific written authorization you provide may be revoked by you at any time, by writing to us at the address provided at the end of this notice.

For treatment

We may use your medical information to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, caregivers, or other people who are taking care of you. We may share medical information about you to other health care providers you designate to assist them in treating you.

For assistance applying to the Colorado Medical Marijuana Registry

We may use and disclose your personal medical information to the Colorado Department of Public Health and Environment and the Colorado Marijuana Enforcement Division as needed to help you join the Colorado Medical Marijuana Registry and associated programs.

For payment

We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

For reminders

We may call, email, text, or send you mail and/or messages regarding appointments, annual visits, follow-ups, and reminders.

4. Your individual rights

You have the right to

- Look at or get copies of certain parts of your medical information. You must make your request in writing.
- Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
- Request that we communicate with you about your medical information by different means or at different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing.
- Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us:

Martha Montemayor, General Manager
Healthy Choices Unlimited
5101 E Colfax Ave
Denver CO 80220

Welcome to Healthy Choices Unlimited
Consent for Medical Evaluation Regarding Cannabis

I, (print name) _____, am at least the age of 18, (or the parent or guardian for the patient) and believe that I have at least one of the debilitating medical conditions or symptoms listed below, as defined by the Colorado Medical Marijuana Amendment. I further believe that Medical Marijuana, also known as cannabis, may help ease my condition(s) or symptom(s). I have attempted to obtain and provide copies of my relevant medical records regarding any previously diagnosed debilitating medical condition(s) or symptom(s).

Please check the condition(s) or symptom(s) below for which you seek treatment with medical cannabis.

I have been diagnosed with and am currently in treatment for one of the following ***Debilitating Medical Conditions:***

❑ Cancer ❑ Glaucoma ❑ HIV or AIDS

I have a medical illness – or a current medical treatment – that causes one or more of the following ***Debilitating Medical Symptoms:***

❑ Severe pain - including (but not limited to) arthritis, migraines, back pain, neck pain, knee pain, accident recovery, post-operative pain, gout, neuropathy, fibromyalgia, abdominal pain, TMJ, etc.

❑ Severe nausea - including (but not limited to) side-effects from medications, such as antidepressants, anti-anxiety meds, sleep aids, etc.

❑ Seizures - including epilepsy

❑ Persistent muscle spasms - including multiple sclerosis

❑ Cachexia - extreme physical wasting, with weight loss and muscle loss

❑ PTSD – Post Traumatic Stress Disorder
Name diagnosing doctor or mental health professional _____

I understand that I am consulting with a physician to obtain an opinion as to whether or not I might benefit from the medical use of cannabis. In performing an evaluation of my medical condition as it relates to determining if I might benefit from medical use of cannabis, a bona fide physician-patient relationship is established for the purpose of fulfilling the physician's role as defined in the Colorado Medical Marijuana Amendment. Our physicians advise you to consult both with us and with your primary care provider at least once a year to re-evaluate your debilitating medical condition.

I understand if the physician's opinion is that medical use of cannabis may benefit me, the decision to use medical cannabis is still at my sole discretion as a patient. If I choose to use medical cannabis, I understand that cannabis may cause side effects, such as drowsiness, dizziness, decreased reaction time, and decreased coordination, and I must avoid hazardous activities, such as driving a vehicle and operating heavy machinery, when using medical marijuana. I understand that, as with any drug, there is a risk of dependence or addiction.

If I plan to become pregnant or breastfeed, I will tell the physician and discuss the potential risks that cannabis poses to my unborn or newborn baby.

Our physicians in no way imply or recommend that you purchase medicinal cannabis from any specific dispensary or caregiver.

Signature _____ Date _____

Name _____

Do you need help filling out forms? Y N Reason: Physical Restriction Eyesight/Reading Issue Child

Name of person Helping if Yes: _____

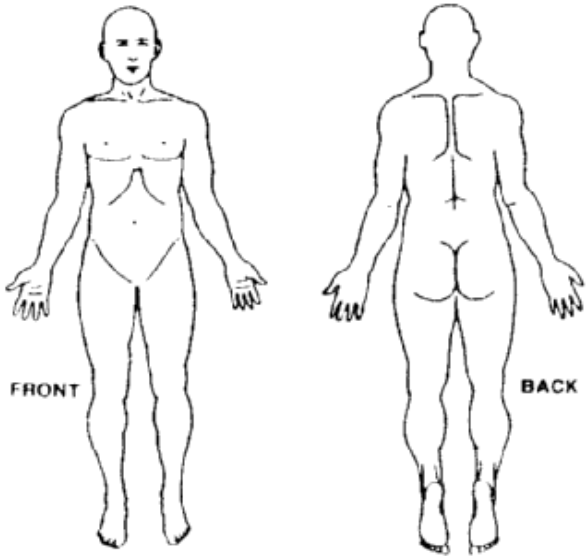
Date of Birth _____ Age Today _____ Are you pregnant? Yes _____ No _____ Maybe _____

Allergies? _____

Your major health issues

1. _____ Date began? _____ How Began? _____
2. _____ Date began? _____ How Began? _____
3. _____ Date began? _____ How Began? _____
4. _____ Date began? _____ How Began? _____

Mark your areas of Pain



Your past medical history (Include Illness, Injuries, Surgery, etc)

_____

_____

_____

_____

_____

_____

_____

_____

Other things you have tried - check / circle all that apply.
Write in name of medicines if you know it.

Medications Tried: _____ ❑Pain Medications
❑Muscle Relaxants ❑Anti-inflammatories ❑Steroids ❑Anti-Depressants ❑ Anti-anxiety ❑Sleep Aids

Any Side Effects of meds? _____

Current Prescription Medications: _____

_____

Over-the-counter drugs or supplements: _____

Other therapies tried: ❑ Ice / Heat ❑Massage ❑ Acupuncture ❑ Chiropractic ❑ Physical Therapy ❑Yoga
❑Pool Therapy ❑Tens Unit ❑ Hot tub ❑Splints /wraps ❑ Orthotics/Insoles ❑Cane/Walker
❑Injections of: ❑ pain killers ❑Steroids ❑ Nerve blocks ❑Other: _____

Your current treatments _____

Your primary physician or clinic _____ Phone_____

Signature: _____ Date _____

How long have you been using medical marijuana? _____ Check forms most commonly used:

❑Smoke ❑Vaporize ❑Edibles ❑Capsules ❑Tinctures ❑Salves ❑Patches ❑ Other

Strain or Type _____ How much? _____ How often? _____

How has it helped your quality of life? (examples: less pain, better sleep, fewer seizures, etc)

_____

Any negative effects? _____

Have you been able to reduce or stop RX or other drugs? _____

Other comments _____

All Patients

Tobacco use? ❑ Yes ❑ No If Yes, how much? _____ Alcohol use? ❑ Yes ❑ No If Yes, how often? _____

Is reducing use of prescription drugs, over-the-counter drugs, tobacco or alcohol a goal for you? ❑ Yes ❑ No

Personal & Family History

	You	*Family*		*You*	*Family*
Skin rashes / eczema			Back Trouble/Injury		
Liver Trouble			Swollen Joints		
Hepatitis			Rheumatism or Arthritis		
Jaundice			Fracture of Bone		
Gallbladder trouble			Carpal Tunnel Syndrome		
Cancer			Tendonitis		
High Blood Pressure			Sleep Disorder		
Heart Trouble			Depression		
Heart Attack			Nervous Breakdown		
Congestive Heart Failure			Bipolar Disorder		
Swelling of Ankles			Schizophrenia		
Fainting / Dizzy Spells			Glasses for reading or distance		
Varicose Veins			Color Blindness		
Venereal Disease			Blood Disorder		
Convulsions or Seizures			Diabetes		
Head Injury			Thyroid Disease		
Stroke (CVA)			Stomach Ulcer		
Paralysis			Frequent Nausea		
Numbness of hands or feet			Frequent Bowel Trouble		
Double Vision			Frequent Diarrheaor Constipation		
Glaucoma			Hernia or Rupture		
Migraine Headaches			Difficulty Hearing		
Asthma			Blood in Urine		
Hay Fever			Kidney Trouble		
Bronchitis			Bladder Trouble		
Shortness of Breath			Bleed Easily / Bruise Easily		
Tightness of Chest			Frequent or severe menstrual pain		
Frequent/ Chronic Cough			Cancer: Radiation or Chemo		
Tuberculosis			Dental problems		
Emphysema			TMJ / Jaw or Facial Pain		
Weight Loss					

:

Patient Signature: _____ Date: _____