

Office Use Only! MAIL \_\_\_\_\_ ONLINE \_\_\_\_\_ Other \_\_\_\_\_ PC-20 \_\_\_\_\_ - \_\_\_\_\_

OV \_\_\_\_\_ Pkg \_\_\_\_\_ IPC \_\_\_\_\_ CC/Not \_\_\_\_\_ Other \_\_\_\_\_ Total Pd \_\_\_\_\_ By \_\_\_\_\_

User Name:

Password:

### Healthy Choices Unlimited Patient Registration Form

Last Name	First Name	Middle Init.
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Patient Social Security # (Required by State of CO)	Birth date / / Mo Day Yr	Age	Gender M <input type="checkbox"/> F <input type="checkbox"/> X <input type="checkbox"/>
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Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> It's Complicated	Name of parent or guardian, if applicable
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Home phone #	Cell Phone #
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Email Address

Mailing Address

City	County	ZIP Code
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Preferred appointment / clinic communications:  Email  Cell phone  Text  Home phone  US Mail

Occupation	Employer <i>We ask only for care purposes, since your work affects your health.</i>
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How did you hear about us?  Returning Patient  Family/Friend  Internet /Website  Westword  Nickel Ads  
 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? <input type="checkbox"/> Apply and receive via US Mail <input type="checkbox"/> Apply Online / print yourself	Who will grow your medicine? <input type="checkbox"/> Myself <input type="checkbox"/> I Don't Know <input type="checkbox"/> Caregiver name: <input type="checkbox"/> Dispensary name:
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Are you Homebound? (unable to go out alone) <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you requesting more than 6 plants today? <input type="checkbox"/> Yes <input type="checkbox"/> No
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#### 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 by electronic means and US Mail.

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

# Consent for Medical Evaluation Regarding Cannabis

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

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, essential tremor, etc.
- Cachexia - physical wasting, with weight loss and muscle loss

I have been diagnosed with and/or am currently in treatment for one of the following

**Disabling Medical Conditions:**

- ASD – Autism Spectrum Disorder  
Name diagnosing Dr or health professional \_\_\_\_\_
- PTSD – Post Traumatic Stress Disorder  
Name diagnosing Dr or mental health professional \_\_\_\_\_
- Pain for which I would otherwise use an opiate / I want to stop using opiates

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

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.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Name \_\_\_\_\_

Do you need help filling out forms? Y N Name of person Helping if Y: \_\_\_\_\_

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? \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

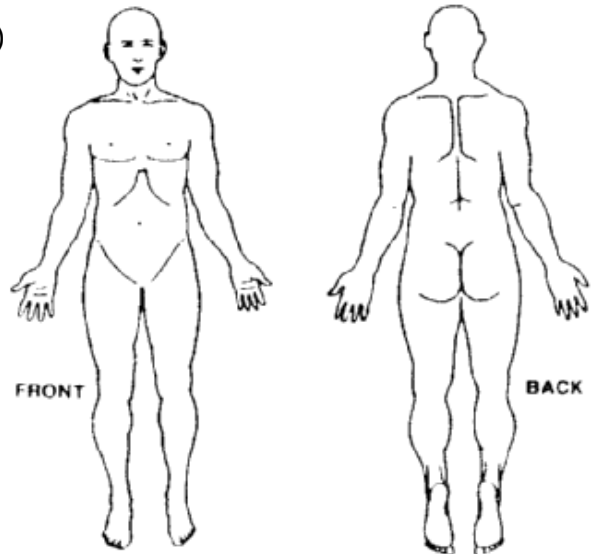
\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Mark your areas of Pain



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 \_\_\_\_\_

Do you have Health Insurance?  Yes – 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.*

Signature \_\_\_\_\_ Date \_\_\_\_\_

# Personal & Family History

	You	Family
Skin rashes / eczema		
Liver Trouble		
Hepatitis		
Jaundice		
Gallbladder trouble		
Cancer		
High Blood Pressure		
Heart Trouble		
Heart Attack		
Congestive Heart Failure		
Swelling of Ankles		
Fainting / Dizzy Spells		
Varicose Veins		
Venereal Disease		
Convulsions or Seizures		
Head Injury		
Stroke (CVA)		
Paralysis		
Numbness of hands or feet		
Double Vision		
Glaucoma		
Migraine Headaches		
Asthma		
Hay Fever		
Bronchitis		
Shortness of Breath		
Tightness of Chest		
Frequent/ Chronic Cough		
Tuberculosis		
Emphysema		
Weight Loss		

	You	Family
Back Trouble/Injury		
Swollen Joints		
Rheumatism or Arthritis		
Fracture of Bone		
Carpal Tunnel Syndrome		
Tendonitis		
Sleep Disorder		
Depression		
Nervous Breakdown		
Bipolar Disorder		
Schizophrenia		
Glasses for reading or distance		
Color Blindness		
Blood Disorder		
Diabetes		
Thyroid Disease		
Stomach Ulcer		
Frequent Nausea		
Frequent Bowel Trouble		
Frequent Diarrhea or Constipation		
Hernia or Rupture		
Difficulty Hearing		
Blood in Urine		
Kidney Trouble		
Bladder Trouble		
Bleed Easily / Bruise Easily		
Frequent or severe menstrual pain		
Cancer: Radiation or Chemo		
Dental problems		
TMJ / Jaw or Facial Pain		

## EVERYBODY

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

## Renewals / Current Cannabis Users

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)

Other comments: \_\_\_\_\_

Any negative effects? \_\_\_\_\_

Have you been able to reduce or stop other drugs?  Yes  No

Signature \_\_\_\_\_

Date \_\_\_\_\_