1217 Shore Road
Suite 202
Ocean View, NJ 08230
(609) 602-7386

Patient Registration

Date:

Last Name: First Name:

Date of Birth: Gender: Select... Last 4 Digits of SS#:

Physical Address
Note: MCP ID will be mailed to this address
Address: Address (Line 2):

City: State: NJ Zipcode:

County: Municipality:

Current New Jersey Driver's License or State ID card issued through NJMVC:

Email:

Phone (mobile): Phone (secondary):

Apple ◯ Android ◯

Primary Physician:

Referred by:

Preferred ATC: Select a Dispensary...

I acknowledge that MMJPM and my physician do not diagnose, treat patients, or prescribe medication. You must be under the care of another physician who has diagnosed you and is treating you.

MMJPM and my physician will review your records and evaluate you. If you meet state requirements, we will certify you to enroll in the medical marijuana program.

We do not issue medical marijuana ID cards, but we will help you enroll in the program. Also, we do not dispense medical marijuana.

Once you get certified you must keep your certification up by continuing in to be evaluated by your physician.

I acknowledge that the fee structure has been explained to me and the only methods of payment accepted is credit card. Fees are collected prior to each visit

_____

Patient Signature

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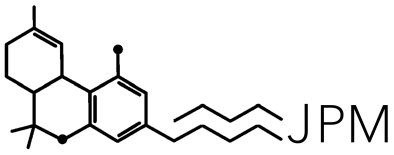

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HIPAA Release of Information Authorization Form

I, _____, hereby authorize MMJPM,
Print name of patient
its employee and agents to release my personal health information relating to the diagnosis treatment and health care services provided or to be provided to me.

This authorization for release of information covers the period of healthcare from today's effective date until authorization is rescinded in writing.

I further understand that this authorization is voluntary and that you may refuse to sign this authorization.

I understand I have the right to revoke this authorization in writing at any time.

I also have the right to exclude authorization for the following items:

_____

_____

_____

_____

_____

_____ _____

Print name of patient Signature of patient

_____ _____

Print name of witness Signature of witness

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Physician / Patient Disclaimer and Release Form

I, _____, being of sound mind, have read and understand the following:
Print name of patient

1. My physician has evaluated my medical condition / conditions and confirmed that I am qualified to be enrolled in the New Jersey Medicinal Marijuana Program.
2. My physician has explained to me that marijuana can interact with many other medicines and ingested substances. Therefore, since the scope of these interactions are unknown and may vary even in the same individual, I should not use marijuana while taking any other mind-altering substances or medicines *without first consulting with my physician*.

These include, but are not limited to:

- Alcohol
- Antidepressants (SSRIs, Tricyclic, Atypical)
- Antipsychotics
- Sedatives (Valium, Ativan, Clonopin)
- Opiates and other analgesics (tramadol, Percocet, Vicodin, Methadone, OxyContin)
- Antihistamines (Benadryl)
- Hypnotics (Ambien, Lunesta, Valium)
- Anxiolytics (Xanax, Ativan)
- Asthma medicines and inhalers
- Chronic Obstructive Pulmonary Disease medicines and inhalers

3. I fully understand that marijuana remains illegal under federal law.
4. I agree not to drive under the influence of medicinal marijuana or operate any machinery or equipment.
5. My physician and office staff will not be held responsible in any way for any untoward effects, directly or indirectly related to my use of medicinal marijuana.
6. My physician has explained to me that THC (delta-9-tetrahydrocannabinol) and all other constituents of marijuana have not undergone rigorous scientific studies or empiric studies to determine all the effects and potential effects it can have on me, my health, my behavior, and my lifestyle.
7. I understand that possible consequences of marijuana use include but may not be limited to: Depression or worsening depression; Frank psychosis; Anti-social behaviors; and other complications which may lead to death in susceptible individuals.
8. I accept all responsibility for any and all fallout from my decision to use medicinal marijuana.
9. I understand and agree to use medicinal marijuana only in private locations and adhere to all NJMMP patient rules and regulations.
10. I will not share or sell my medicinal marijuana with / to family, friends, strangers, or any other person or persons. Possession, use, and sale of medicinal marijuana remains illegal under federal law, the state may not be able to protect you from prosecution by the federal government.

_____ _____
Patient Signature Date

_____
Physician Signature

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Name: Date:

Chief Complaint or Qualifying Diagnosis:

If you have chronic pain:

1. Location of pain:
2. Severity of pain on a scale of 1 to 10:
3. When pain began?
4. Was there an event or condition that caused the pain?
5. What treatments have you received?

_____
_____
_____

If you have anxiety:

1. When did it begin?

2. What treatments have you received?

All other qualifying diagnosis:

1. When did it begin?
2. What treatments have you received?

3. What symptoms cause the most discomfort?

_____
_____
_____

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Social History

What is your marital status? ☐ Single ☐ married ☐ divorced ☐ widow

Do you smoke? ◯ Yes ◯ No How many packs per day?

Do you drink alcohol? ◯ Yes ◯ No How much per week?

Do you take street drugs? ◯ Yes ◯ No What?

Medical History

Medication:

Are you taking any medication now? ☐ YES ☐ NO *If yes fill out chart.*

Drug Name	Dose	Start date	Reason
1.			
2.			
3.			
4.			
5.			
6.			
Have you experienced any side effects?			

Allergies:

Are you allergic to any Medications? ☐ YES ☐ NO *If yes fill out chart.*

Drug name	Date of reaction	Type of reaction
1.		
2.		
3.		

Surgical History:

Please list any surgery you have had no matter how long ago or small it was:

Surgery	Date
1.	
2.	
3.	
4.	
5.	
6.	

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Family History

Do any of your blood relatives have any of the following diseases?

Please check if yes or no.

Disease	Yes	No	Relation
Bleeding Disorder	○	○	
Cancer	○	○	
Diabetes	○	○	
Heart Disease	○	○	
High Blood Pressure	○	○	
Stroke	○	○	

Doctors Notes

_____
_____
_____
_____
_____

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Review of Systems

Constitutional:
- ☐ Eating Disorder
- ☐ General Weakness

Hematology/ Lymphatic:
- ☐ Easy bruising
- ☐ Swollen lymph nodes
- ☐ Anemia
- ☐ Poor Blood Clotting

Cardiovascular:
- ☐ Heart attack
- ☐ High blood pressure
- ☐ Blood clot or embolism
- ☐ Heart murmur
- ☐ Chest Pain
- ☐ Difficulty Breathing

Respiratory:
- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ Emphysema COPD

Musculoskeletal:
- ☐ Arthritis
- ☐ Painful or swollen joints

Gastrointestinal:
- ☐ Irritable bowel
- ☐ Nausea or vomiting
- ☐ Diarrhea or constipation
- ☐ Chronic indigestion

Urinary Tract:
- ☐ Kidney stones
- ☐ Frequent bladder infections

Endocrine:
- ☐ Diabetes
- ☐ Thyroid disorder

Neurologic:
- ☐ Epilepsy or seizures
- ☐ Stroke
- ☐ Migraine headaches

Psychiatric:
- ☐ Anxiety
- ☐ Depression

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Name:

DOB:

Date:

GAD-7 Anxiety Assessment

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing				
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Total score: _____

0-4: negative anxiety screen
5-9: mild anxiety
10-14: moderate anxiety
15+: severe anxiety

Reference:

Spitzer RL, Kroenke K, Williams JB, Löwe B. A brief measure for assessing generalized anxiety disorder: the GAD-7. Arch Intern Med. 2006 May 22;166(10):1092-7. doi: 10.1001/archinte.166.10.1092. PMID: 16717171.

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