Medical Marijuana Group
PO Box 20070
RPO Edward Street
St. Thomas, ON
N5P 4H4

P: 1-844-444-4664
F: 1-833-222-2664
E: info@medmg.ca

Patient Information

First Name: ______________ Middle Name: ______________
Preferred Name: ____________ Last Name: ______________
Date of Birth (YYYY/MM/DD): ______/______/______
Gender: ☐ Male ☐ Female ☐ Other
Address: ______________________________
City: ____________________ Province: ______________
Postal Code: ______________ Phone: ______________
Email: ______________________________
Health Card #: ______________________________

Do you classify yourself as any of the following? ☐ Military/RCMP/First Responder ☐ MVA Victim ☐ FNMI

Are you interested in growing your own cannabis? *(fees may apply)* ☐ Yes ☐ No

Are you interested in applying to have cannabis covered through private insurance? ☐ Yes ☐ No

Self-Assessment

I'm seeking cannabis to treat: ______________________________

____

This symptom prevents me from being able to: ______________________________

____

Known allergies to medications and reactions: ______________________________

____

Products and Services (optional) — **Please select all that apply.**

Cannabis Products

☐ Dried Cannabis ☐ Milled Cannabis ☐ Capsules ☐ Oils ☐ Sublingual Sprays

Compounded Pain Creams

☐ Joint and Inflammation ☐ Muscle Relaxant ☐ Neuropathic Pain ☐ Muscle & Soft Tissue Pain ☐ Migraines

Extended Health Benefits (optional)

Provider: ______________________________ Carrier Number: ______________________________
Policy Number: ______________________________ ID/Certificate Number: ______________________________

Emergency Contact (optional)

First Name: ______________ Last Name: ______________ Relationship: ______________
Phone: ______________ Email: ______________________________
I give MMC consent to speak to this person about my cannabis treatment. ☐ Yes ☐ No

Physician Information (optional)

Physician's Name: ______________________________ Phone: ______________ Fax: ______________

CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

I, ____________________________ (first and last name), acknowledge, agree, and/or grant permission to Medical Marijuana Group to access my prescription, medical documents, and/or personal health information, which may consist of dosing information of topical compound creams and/or cannabis used for medical purposes, which is used as verification of the healthcare practitioner's order required by a physician, pharmacy, or licensed producer.

I grant permission to the pharmacy or licensed producer of my choosing, specified on the prescription or medical documents, to share my application and related materials with your insurance provider including recommended dose information for the purpose of facilitating direct billing for insurance purposes. I also grant the pharmacy or licensed producer permission to disclose personal and sales-related information to Medical Marijuana Group for tracking and information purposes.

I acknowledge the indications, safety, and understand that the risks of dried cannabis use has not been adequately studied and that the appropriate dose is unclear and may vary from person to person. I acknowledge that any medical cannabis product obtained from a licensed producer is done so at my own risk and I release Medical Marijuana Group from all and any actions, claims, complaints, and demands for damages, loss, or injury whatsoever, arising directly or indirectly as a consequence of the use of medical cannabis products.

I understand that the purpose of disclosing this personal health information to the company noted above is in order to provide products or services offered by Medical Marijuana Group. I understand that I can refuse to sign this consent form. I have not been coerced to sign this consent form and am signing this form under my own free will.

By my signature below, I certify that the information on this form and in connection with my registration, is true and accurate. I acknowledge that I am responsible for the information that I provided and any costs associated with providing false information.

Signature: ____ Date (YYYY/MM/DD): _______/_______/_______

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