



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 #: _____

How would you classify yourself? First Responder RCMP Still Serving Veteran **Service #:** _____

For veterans, do you have an awarded condition? Yes No If yes, please list here: _____

Are you interested in growing your own cannabis? Yes No

Physician Assessment

I'm seeking cannabis to treat: _____

 This symptom prevents me from being able to: _____

 Known allergies to medications and reactions: _____

Products and Services		Please select all that apply.
<p><u>Cannabis Products</u></p> <input type="checkbox"/> Dry Cannabis <input type="checkbox"/> Milled Cannabis <input type="checkbox"/> CBD Oil <input type="checkbox"/> THC Oil <input type="checkbox"/> 1:1 Oil <input type="checkbox"/> Capsules <input type="checkbox"/> Sublingual Sprays	<p><u>Compounded Pain Creams</u></p> <input type="checkbox"/> Joint and Inflammation <input type="checkbox"/> Neuropathic Pain <input type="checkbox"/> Migraines <input type="checkbox"/> Muscle Relaxant <input type="checkbox"/> Muscle & Soft Tissue Pain	<p><u>Services</u></p> <input type="checkbox"/> Coverage <input type="checkbox"/> Veteran Benefit Support <input type="checkbox"/> Cannabis ID Card <input type="checkbox"/> Licensed Producer Discount for Still Serving Members and First Responders

Emergency Contact

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

Physician Information

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 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): ____/____/____