MEDICAL CANNABIS INTAKE FORM

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All of the information you provide in this questionnaire is confidential and follows all privacy practices

NAME: _____ DATE: _____

TELEPHONE: DAY: _____ CELL: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

MALE/FEMALE

DATE OF BIRTH: _____

AGE: _____ Email: _____ Occupation _____

PERSON TO CONTACT IN CASE OF EMERGENCY:

_____

Relationship: _____

Telephone: _____

Primary Caregiver (if any): _____

NAME and PHONE NUMBER OF PRIMARY CARE PROVIDER OR SPECIALIST(S) FOR YOUR CURRENT CONDITION(S)

_____

_____

MEDICAL CONDITION(S) FOR WHICH YOU ARE SEEKING MEDICAL CANNABIS (Include dates)

_____

_____

WHAT TREATMENTS HAVE YOU HAD INCLUDING, BUT NOT LIMITED TO SURGERY, MEDICATIONS, AND THERAPIES FOR YOUR CURRENT CONDITIONS(S)?

_____

_____

MEDICATIONS WHICH YOU ARE CURRENTLY TAKING and FOR WHAT MEDICAL CONDITIONS:

_____

_____

LIST SYMPTOMS FOR WHICH YOU ARE SEEKING MEDICAL CANNABIS:

_____

_____

WHY WOULD MEDICAL CANNABIS BENEFIT YOU?

_____

_____

HAVE YOU USED CANNABIS/MARIJUANA FOR YOUR MEDICAL CONDITION(S)? IF WHAT PRODUCTS AND METHOD(S) OF ADMINISTRATION:

_____

PERSONAL MEDICAL HISTORY:

Please indicate whether you have had any of the following medical condition with a check and date of occurrence (Year)

Heart disease ☐ Stroke ☐ Heart attack ☐

Bleeding/clotting problem ☐ Cancer (type and location) ☐

High cholesterol ☐ Diabetes ☐ High Blood Pressure ☐

Lupus ☐ MS ☐ Epilepsy ☐ Parkinson's ☐ HIV/AIDS ☐

Glaucoma ☐ Crohn's Disease ☐ Ulcerative colitis ☐ IBD ☐

Fibromyalgia ☐ Arthritis (type and location _____

Wasting Syndrome ☐ Neuropathy (location(s) _____

Inability to tolerate food, nausea, vomiting, dysphasia _____

Spinal cord injury with objective neurological findings_____

Chronic Pain (location(s) and cause _____

Neck, Back , Spinal Condition(s) _____

ALS (Lou Gehrig's Disease) _____

PTSD _____

PSYCHIATRIC DISORDER _____

I have answered the above questions honestly and completely to the best of my ability.

SIGNATURE OF PATIENT OR CAREGIVER : _____

PRINTED NAME : **_____**

DATE: _____

Janis L. Enzenbacher, MD
ACKNOWLEDGEMENT OF RECEIPT OF
PATIENT NOTICE OF PRIVACY PRACTICES

I acknowledge that I read and/ or received a copy of the Janis L. Enzenbacher, MD: Patient Notice of Privacy Practices/ HIPAA effective January 1, 2015

Date: _____

Print Name: _____

Patient Signature: _____
(or guardian, if applicable)

Please be advised that I _____ do not want give any authority or consent to give out any information of my medical history or diagnosis with any party. Under no circumstances should my medical history be given to anyone.
Date: _____

Patient Signature: _____

PRACTICE POLICY & PAYMENT AGREEMENT:

Payment for all services including; ALL CONSULTS, and recommendations for treatment must be paid in full at the time of the visit for services rendered.

Payment can be made with credit/debit card, cash or check. **Payments made with credit/debit card will incur a 3% processing fee.** We charge a processing fee for all returned checks. Outstanding balances beyond 30 days will be charged a monthly interest fee of 1.5%.

The above services are not typically covered by medical health insurance companies including Medicare. Upon request, we can provide a receipt for services rendered. All services above are non-refundable.

I, _____, understand that I am responsible for the balance of my account, for any and all professional services rendered on my behalf. I accept full responsibility for the payment of these services.

Cancellation Policy

Cancellations for all appointments must be made within 24 hours of the scheduled appointment. This can be done by leaving a message at 914-325-1664 or email at janiszen@drgyn.us.If the appointment is not cancelled within this time period then you will be charged 75% of the cost of service. Exceptions will be made with the discretion of practitioner.

Print Name _____

Signature _____ Date _____