The Botanist™

CANNABIS DISPENSARY

Patient Intake Form

CONTACT INFORMATION

Name: _____

Nickname: _____

Gender: _____

Date of Birth: _____

Phone Number: _____

Secondary Phone Number: _____

Residential Address: _____

_____

Email: _____

Would you like to be added to our email list? Y N

Staff completion, if needed? _____

GENERAL MEDICAL INFORMATION

Primary Care Physician: _____

Are you pregnant, breast feeding, or planning to become pregnant? _____

Are you on any of the following medications?

Blood Thinners: Y / N _____

Heart Medications: Y / N _____

Organ Transplant Medications: Y /N _____

**Please be prepared to provide a full list of your medications to the Pharmacist during your Intake Appointment. This is necessary to screen for any potential drug interactions. **

REFERRAL INFORMATION

How did you hear about us? _____

Referral Points Added, if Needed? Y / N

DISCOUNTS

Are you a Veteran? Y / N

APPOINTMENT INFORMATION

Date of Appointment: _____

Time of Appointment: _____

Appointment and Profile Created by: _____

Profile Checked by: _____

Staff Notes: _____

_____

REGISTRATION INFORMATION

Patient ID No: _____

Allotment in Ounces: _____

Qualifying Condition: _____

_____

_____

_____

Authorized Physician: _____

Does the Patient Have a Registered Caregiver?

Name: _____

Caregiver ID No: _____

Phone Number: _____

TRANSFER INFORMATION

Previous Dispensary: _____

Remaining Allotment in Ounces: _____

First Purchase: _____

Allotment Reset Date: _____

Who called for Transfer Information: _____

Who gave the Transfer Information to us from the Previous Dispensary: _____

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CONSULTATION WAIVER

If you prefer to waive your free consultation with one our Pharmacists, please sign below. If at any point you have questions, concerns, or would like tailored advice from one of our pharmacists, please call us to schedule a consultation appointment, so we can better assist you. **By signing below you are acknowledging that you are aware of the risks and benefits of Cannabis, you have a basic knowledge of the components of the Cannabis Plant and the different methods of consumption and how it affects you. You are also acknowledging that you declined to be counseled on the effects of Cannabis by a registered dispensary pharmacist, free of charge.**

*Sign Here:*_____ *Date:*_____

PHARMACIST NOTES

Pharmacist Completing Consultation: _____

PMP Checked: Y / N

Physician's Instructions Checked? Y / N

Marijuana History: Y / N

Special Instructions from MD, if Applicable:	Symptoms to be Alleviated:
Suggestions and Preferences:	Medications:
Allergies:	Other Health Conditions: