



**Medical Marijuana Consulting**  
**124 Wellington Street E**  
**Aurora, ON**  
**L4G 1J1**

**P: 1-844-312-5143**  
**F: 1-844-633-6422**  
**E: associates@medmc.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  WCC

**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 Consulting 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 Consulting 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 Consulting 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 Consulting. 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): \_\_\_\_/\_\_\_\_/\_\_\_\_