Medical Marijuana Consulting
535 Talbot Street
St. Thomas, ON
N5P 1C3

P: 1-844-312-5143
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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 #: _____

How would you classify yourself? ☐ Civilian ☐ Military/RCMP/First Responder ☐ MVA Victim ☐ FNMI ☐ WCC

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.**
Cannabis Products	**Compounded Pain Creams**	**Services**
☐ Dry Cannabis	☐ Joint and Inflammation	☐ Compassionate Pricing
☐ Milled Cannabis	☐ Neuropathic Pain	☐ Coverage
☐ CBD Oil	☐ Migraines	☐ Veteran Benefit Support
☐ THC Oil	☐ Muscle Relaxant	☐ MVA Claims/Treatment Plans
☐ 1:1 Oil	☐ Muscle & Soft Tissue Pain	☐ Cannabis ID Card
☐ Capsules		☐ Pharmacy Delivery
☐ Sublingual Sprays		☐ Nursing Home Advocacy

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 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 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): _____/_____/_____

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