



### New Patient Intake Form

FOR OFFICE USE ONLY: Consult/No Consult	<input type="checkbox"/>	Form Reviewed by RPh _____	<input type="checkbox"/>	Patient Data Entered _____
<input type="checkbox"/>	420 Plymouth Road, Plymouth Meeting	<input type="checkbox"/>	2405 Covered Bridge Drive, Lancaster	

#### DEMOGRAPHIC INFORMATION

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 (First) (Last) (MM) (DD) (YYYYY)

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 (Street)

\_\_\_\_\_(City) \_\_\_\_\_(State) \_\_\_\_\_(Zip) Email: \_\_\_\_\_

#### IF APPLICABLE

PA Department of Health Certified Caregiver Name: \_\_\_\_\_

Caregiver Relationship to Patient: \_\_\_\_\_ Caregiver Phone: \_\_\_\_\_

**How did you hear about Apothecarium dispensary?**  Friend/Family  Web Search  
 Physician  Social Media  Leafly/Weedmaps  Event (which event) \_\_\_\_\_

#### MARIJUANA CERTIFICATION

Medical Marijuana Card Issue Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Expiration Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 (MM) (DD) (YYYY) (MM) (DD) (YYYY)

Name and Specialty of Approved Certifying Physician: \_\_\_\_\_

Facility Location: \_\_\_\_\_  
 (Street) (City)

Certifying Physician's Phone: \_\_\_\_\_



**SOCIAL HISTORY**

Have you used marijuana in the past?  YES  NO

Are you currently using marijuana?  YES  NO  
 If "YES", how often? \_\_\_\_\_ per month \_\_\_\_\_ per week \_\_\_\_\_ per day

Do you use any form of nicotine:  YES  NO  
 If "YES", what form and how often?    Nicotine type: \_\_\_\_\_                      Nicotine Usage: \_\_\_\_\_ per \_\_\_\_\_

Do you drink alcohol?  YES  NO  
 If "YES", how often?                      Alcohol Usage: \_\_\_\_\_ drinks per \_\_\_\_\_

Do you use any other substance?  YES  NO  
 (example: opioids not prescribed to you, cocaine, LSD, etc.)  
 If "YES", what form and how often?    Substance type: \_\_\_\_\_                      Substance Usage: \_\_\_\_\_ per \_\_\_\_\_

Other Comments: \_\_\_\_\_

**FOR OFFICE USE ONLY**

Date of Initial Consult: \_\_\_\_\_

30-day DOH Limit: \_\_\_\_\_ grams/30 days                      Name of Dispensary Employee for Initial Intake: \_\_\_\_\_

30-day limit set initially set by Ilera HCP?  YES  NO                      Signature of Dispensary Employee: \_\_\_\_\_

Any restrictions set by certifying physician?  YES  NO  
 If "YES", please list: \_\_\_\_\_

Comments: \_\_\_\_\_

THE  
APOTHECARIUM  
DISPENSARY

Please initial next to each statement then sign and date the bottom of this form.

\_\_\_\_\_ I understand that I can only purchase medical marijuana product with a valid Pennsylvania Medical Marijuana Card and valid certification in place.

\_\_\_\_\_ I understand, acknowledge, and confirm that the cannabis plant is not regulated by the Food and Drug Administration and is listed as a Schedule I Controlled substance with the U.S. Drug Enforcement Agency. I understand, acknowledge and affirm that it is unlawful for anyone other than a patient/caregiver with a valid medical marijuana card to possess or use medical marijuana products. I understand and acknowledge that it is illegal to divert, transfer, sell, or give any medical marijuana product purchased to anyone other than the patient/caregiver to whom it was dispensed.

\_\_\_\_\_ I understand, acknowledge, and affirm that it is unlawful for any person under the age of 18 to obtain or use medical marijuana products unless they are a patient. I agree to keep all medical marijuana products out of reach of children, other than when a caregiver is administering to a patient.

\_\_\_\_\_ I understand that medical marijuana contains psychoactive ingredients that may affect my coordination, motor skills, and cognition in ways that could impair my ability to drive, operate heavy machinery, or engage in potentially hazardous activity. I understand that there are side effects associated with using medical marijuana and have discussed the risks of medical marijuana with my approved certifying physician.

\_\_\_\_\_ I agree not to open or use purchased medical marijuana products within 1000 feet of Apothecarium dispensary facility or any other place as prohibited by law. I understand it is recommended to use my medical marijuana product within the privacy of my own home.

\_\_\_\_\_  
SIGNATURE OF PATIENT OR CAREGIVER

\_\_\_\_\_  
DATE

I have been given a copy of this form.