



New Patient Intake Form

FOR OFFICE USE ONLY: Consult/No Consult Form Reviewed by RPh ____ Patient Data Entered ____
 420 Plymouth Road, Plymouth Meeting 2405 Covered Bridge Drive, Lancaster
 2701 Lincoln Highway E, Thorndale

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 DOH website
 Web Search Google Yahoo Facebook Newspaper
 Leafly/Weedmaps Apothecarium website Physician
 Another dispensary (which one) _____
 Event (which event) _____ Other (specify) _____

THE
APOTHECARIUM
DISPENSARY

FOR OFFICE USE ONLY

Date of Initial Consult: _____

30-day DOH Limit: _____ grams/30 days

30-day limit set initially set by Apothecarium?

YES

NO

Name of Medical Professional for Initial Intake:

Signature of Medical Professional Employee:

Any restrictions set by certifying physician? YES NO

If "YES", please list: _____

Comments: _____

MARIJUANA CERTIFICATION

Medical Marijuana Card Issue Date: ____/____/____
(MM) (DD) (YYYY)

Expiration Date: ____/____/____
(MM) (DD) (YYYY)

Name and Specialty of Approved Certifying Physician: _____

Facility Location: _____
(Street) (City)

Certifying Physician's Email: _____

Certifying Physician's Phone: _____

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.

_____ I consent to receive email communications from The Apothecarium Dispensary. I understand I can opt-out of dispensary communications by clicking "unsubscribe" on any individual email.

SIGNATURE OF PATIENT OR CAREGIVER

DATE

I have been given a copy of this form.