

Welcome
MMD REGISTRATION FORM

Please Print!		Today's Date:	
PATIENT INFORMATION			
Last Name:		First:	Middle:
Social Security #:		Birth date: / /	Age: Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Home phone #:		Cell Phone #:	
Street Address:			
City:		State:	ZIP Code:
Email:		Marital Status: Single / Married / Divorced / Other:	
Occupation:		Employer:	
How did you hear about us?			
Dispensary Name:			
Caregiver Name:			
<input type="checkbox"/> Family/Friend <input type="checkbox"/> Internet <input type="checkbox"/> Advertising <input type="checkbox"/> Other (please list):			
EMERGENCY CONTACT			
Local Friend or Relative:		Phone #:	
Relationship to you:			
INSURANCE INFORMATION			
Do you have Health Insurance? _____ Yes _____ No			
Name of Company:		Insurance phone no:	
<i>MMD does not bill your insurance company for medical marijuana evaluations. We ask for state compliance / office information only. You may request an itemized statement for your visits should you wish to file insurance claims yourself.</i>			
CERTIFICATION			
I Hereby Certify:			
1. The above information is true and correct to the best of my knowledge.			
2. I understand that I am financially responsible for any balance due.			
3. If applicable, I assign insurance benefits to MMD and direct my insurance company to pay MMD Medical Doctors directly.			
4. I have reviewed the Notice of Privacy Practices on the back of this form.			
5. I authorize MMD to release any information required to provide me with care, process my state registry paperwork, and insurance claims.			
Signature		Date	

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION PLEASE REVIEW IT CAREFULLY. IF YOU WOULD LIKE A COPY OF THIS NOTICE PLEASE LET US KNOW AND WE WILL BE HAPPY TO SUPPLY YOU WITH A COPY.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

The Law Requires us to:

- Keep your medical information private.
- Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
- Follow the terms of the current notice

We Have the Right to:

- Change our privacy practices and the terms of this notice at any time, provided the changes are permitted by law.
- Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

- Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed.

We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

FOR TREATMENT: We may use your medical information to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, caregivers, or other people who are taking care of you. We may share medical information about you to other health care providers you designate to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

FOR REMINDERS: We may call, email, or send you mail regarding appointments, annual check-ups, and reminders.

4. YOUR INDIVIDUAL RIGHTS

You have the right to:

- Look at or get copies of certain parts of your medical information. You must make your request in writing.
- Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
- Request that we communicate with you about your medical information by different means or at different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing.
- Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us at:

MMD Medical Doctors
600 Grant St #350
Denver CO 80203

Medical Marijuana Doctors
Consent for Evaluation
of Patient's Suitability for Use of Medical Marijuana

I, _____, believe that I have a debilitating medical condition as defined by the Colorado Medical Marijuana Amendment. I have attempted to obtain copies of my pertinent medical records regarding previously diagnosed debilitating medical condition(s) for this evaluation.

I understand that I am consulting with a physician at the Medical Marijuana Doctors herein known as MMD for the purpose of evaluation of my medical condition to obtain an opinion as to whether or not I might benefit from the medical use of marijuana in connection with a debilitating medical condition as defined by the Colorado Medical Marijuana Amendment. The physician(s) at MMD who evaluate(s) me will base their opinion on the contemporaneous assessment of my medical history and current medical condition.

In performing an evaluation of my medical condition as it relates to determining if I might benefit from medical use of marijuana, a bona fide physician-patient relationship is established for the purpose of fulfilling the physician's role in regulating the Colorado Medical Marijuana Amendment. This bona fide physician-patient relationship is limited to the physician's role as defined in the Colorado Medical Marijuana Amendment and in no way can be construed to have formed a physician-patient relationship for any or all other purposes. The physicians at MMD advise you to consult both with MMD and with your primary care provider at least once a year to re-evaluate your debilitating medical condition.

If the physician's opinion is that I might benefit from the medical use of marijuana, that opinion does not, in any way imply that the physician who evaluates me or MMD is advising me to use medical marijuana. The decision to use medical marijuana is at my sole discretion as a patient. If I choose to use medical marijuana, I understand that marijuana may cause side effects, such as drowsiness, dizziness, decreased reaction time, and decreased coordination; and I must avoid hazardous activities, such as driving a vehicle, and operating heavy machinery when using medical marijuana.

Once you have chosen to ingest medical marijuana, MMD's physicians advise you to assess the benefit you receive from using medical marijuana on an ongoing basis, and continue its use only if it is benefiting your symptoms.

MMD and their physicians in no way imply or recommend that you purchase medicinal marijuana from any specific dispensary or caregiver.

Printed Name: _____ Date: _____

Signature: _____



METRO MULTI-DISCIPLINARY DOCTORS

600 GRANT ST #350 DENVER CO 80203

720-287-3440 tel / 720-287-3432 fax

MMD CLINICAL INTAKE

Name: _____ Age: ___ Date of Birth _____
Hand dominance: Right ___ Left ___ Both ___ Height _____ Weight _____
Current Employment: Part-Time ___ Full-Time ___ Unemployed ___ Retired ___ Disabled ___
Date last worked _____ Type of job _____

CHIEF COMPLAINT: What are your main problems or difficulties? (please circle):
Headaches facial pain neck pain back pain leg pain arm pain joint pain arthritis
cramps/muscle spasms mental or behavioral abdominal pain nausea/vomit seizures/epilepsy
Other problem(s) _____
Do you have Family Members with similar problem to yours? Yes ___ No ___

Average pain (please circle): none / minimal/ mild /moderate/ severe/ worst possible
Worst pain (please circle): none / minimal/ mild /moderate/ severe/ worst possible
What makes your symptoms worse: _____
What makes your symptoms better: _____
Who is your current treating physician? _____
Have you seen any specialists for this problem? _____

PREVIOUS TREATMENTS YOU HAVE TRIED: (please circle):
Pain Killers Muscle Relaxants Anti-inflammatories Steroids Sleeping Pills Anti-Depressants Nerve pills
Marijuana Other meds: _____
Side effects of meds: _____
Ice / Heat Physical Therapy Pool Therapy Massage Acupuncture Chiropractic Exercise
Tens Unit Hot tub Splints or braces Orthotics(Foot cushions) TMJ splint Cane/Walker Wheelchair
Injections of: pain killers / joints / tendons / spine / nerves
Surgery - list areas of body/dates: _____
Other treatments _____
Diagnostics: list any x-rays, MRIs, lab, other studies/ tests done: _____

Do your symptoms cause problems in your regular Activities of Daily Living and Functional Status?
Please circle affected areas: Self Care Personal Space Communication Finances Normal living postures
Ambulation Mobility Arm-hand use Travel Sexual function Sleep Social functioning
Thinking Concentration Judgment Adaptation to stress
Please describe activities you do in an average week (please circle): Take naps/rest Watch TV Read Light
chores Heavy chores Clean house Work Look for work cook simple meals cook family meals eat 2-3
meals daily Visit family/friends exercise sports computer use play games school work party
How do you rate your overall general health? Excellent Very Good Average Fair Poor
Chronic and serious illnesses: _____

Past serious illnesses: _____

Hospitalizations:

Year	Illness/Operation	Remaining Problems

MMD Medical Doctors
Medical Marijuana Discharge Instructions

MMD conforms to and follows the laws and constitution of the State of Colorado and the City of and County of Denver. If our doctors have recommended Medical Marijuana for you, you must comply with the following:

1. Once we have issued our recommendation, it is your responsibility to apply for a State issued identification card from the Colorado Department of Health, so you will be listed on the Colorado Medical Marijuana Registry. You have 60 days following your evaluation to mail your Medical Marijuana Registry Application to the State. We recommend you mail it in with payment as soon as possible by Certified mail. You may use a copy of your application and certified mail receipt as a temporary card only after mailing it to the State, so keep your Post Office receipt to show proof of mailing.
2. The amount of Medical Marijuana you can have in your possession is limited by the constitution of the State of Colorado. Those limits are: no more than 2 ounces of marijuana in usable form; no more than 6 plants with 3 or fewer being mature and flowering.
3. You may possess Medical Marijuana with your temporary card immediately after mailing. However, you must wait 35 days after the date on your mailing receipt before purchasing Medical Marijuana from a dispensary.
4. An opinion from an MMD doctor that Medical Marijuana may benefit your condition is not a prescription and does not imply that the doctor is advising you to use Medical Marijuana. The decision to use Medical Marijuana is at the sole discretion of the patient.
5. Medical Marijuana purchased from a dispensary or provided by your caregiver is for your medicinal purposes only. You should not sell, give away, or otherwise distribute any Medical Marijuana.
6. You should only consume Medical Marijuana at your own residence. It is not for use in public places. Medical Marijuana is not for use by persons under 18 years of age.
7. Medical Marijuana is a drug and will impair your mental faculties and physical abilities. Thus, Medical Marijuana should not be consumed before or while driving a vehicle or operating equipment. Patient will follow-up with his/her Primary Care Provider or with MMD should they experience any adverse effects from the use of Medical Marijuana.
8. Patient understands the Colorado Medical Marijuana Registry allows Medical Marijuana use in the State of Colorado only, and may not be valid in other states.

By signing this form the patient states he/she has read, understands, and agrees to the above listed items.

Patient Name _____

Patient Signature: _____ Date: _____