Strawberry Fields Ohio Patient Information Form

Patient Name*(as written on ID)*: ____
Date of Birth (mm/dd/yyyy): __________________________ Gender: _____M or _____F
Home Address, City, State, & Zip: ____
Phone Number: ____
Email: ____

Certifying Physician's Name: ____
Physician's License Number: ____
OH Medical Marijuana ID #: ____
ID Expiration Date: ____
Patient Certification Date Issued: ____
Expiration Date: ____

Would you like to be contacted regarding dispensary promotions?
Email: _____Yes or _____No
Text: _____Yes or _____No *Standard message/data rates apply*

Emergency Contact: ______________________________________ Phone Number: _____________________
Relation to Patient: _____________________________________
Personal Caregiver Name (if applicable): ____________________ Phone Number: _____________________
Registry ID #: ____
Address, City, State, & Zip: ____

Check the following if they apply to you:
_____I am on SSI, SSDI, and/or Medicare _____I am a Veteran
This information is related to potential qualifications for subsidy program

Qualifying Conditions (please check):
_____AIDS
_____Alzheimer's Disease
_____Chronic Traumatic Encephalopathy
_____Epilepsy
_____Glaucoma
_____Inflammatory Bowel Disease
_____Chronic Pain
_____HIV Positive
_____Sickle Cell Anemia
_____Tourette's Syndrome
_____Ulcerative Colitis
_____Amyotrophic Lateral Sclerosis (ALS)
_____Cancer
_____Crohn's Disease
_____Fibromyalgia
_____Hepatitis C
_____Multiple Sclerosis
_____Parkinson's Disease
_____Post-Traumatic Stress Disorder (PTSD)
_____Spinal Cord Disease
_____Traumatic Brain Injury

All supplied patient information will remain private in accordance with HIPPA regulations

Do you have any preexisting medical conditions? (ex. Heart disease, High Blood pressure)
_____Yes
_____No
If Yes, Explain: ____

Do you have any allergies?
_____Yes
_____No
Is Yes, Explain: ____

Are you pregnant or planning on becoming pregnant?
_____Yes
_____No

Current Medications: ____
____
____

How did you hear about us?
_____Ohio Medical Marijuana Control Program
Referral:
_____Patient
_____Physician
_____Employee
Other: ________________
_____Web Search
Other (please specify): ___________________

For Office Use Only

Form Confirmed By: ______________
Agent Initials:___________________
Date: __________________________

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Patient Waiver of Liability and Hold Harmless Agreement

I, ___________________________(*print name),* am fully aware of the risks and hazards (legal, medical, social, and otherwise) involved with acquiring and using approved medical marijuana products I obtain from Strawberry Fields ("Dispensary") for any purpose, medical or otherwise. I am fully aware that there may be risks and hazards unknown to me, the Dispensary, Dispensary Agents, or any other person with whom I have consulted.

I voluntarily assume full responsibility for any risks, loss, damage, or personal injury (including death) that I sustain as a result of being a customer of Dispensary and/or my procession or use of marijuana.

I hereby indemnify and hold harmless Dispensary and its affiliates, officers, directors, agents, representatives, and employees from and against any and all damages, liabilities, obligations, penalties, fines, judgements, claims, deficiencies, losses, costs, and expenses (including attorneys' fees and costs) arising out of resulting from, or in any wat related to: (i) my being a customer of Dispensary; (ii) the status of any of my licenses or registration cards; (iii)my procession or use of marijuana or any other controlled substance.

It is my express intent that this Waiver of Liability and Hold Harmless Agreement ("Release") bind the members of my family and spouse if I am alive, and my heirs, assigns, and personal representative if I am deceased, and that the Release is deemed a release, waiver, discharge, and covenant not to sue Dispensary or any of its affiliates, officers, directors, agents, representatives, and employees.

In signing this Release, I acknowledge and represent that:

- I have read the foregoing release and indemnification, understand the entire Release, and sign it voluntarily;
- No representations, statements, or inducements (oral or otherwise), apart from the foregoing written agreement, have been made to me regarding medical marijuana or Dispensary;
- I am at least 18 years of age and fully competent; and I execute this Release in full, adequate, and complete consideration fully intending to be bound by the same. Dispensary is relying on this Release in the provision of any service or products to me;
- I have complied with all applicable Ohio Board of Pharmacy regulation regarding the acquisition, use, and procession of medical marijuana, including being in procession of a valid State-Issued Registry Identification Card.

Patient Signature: ____ Date: _____________________

Agent Signature: ____ Date: _____________________

**In the event that a patient is under 18 years old, a legal guardian must execute this Release on the behalf of the Patient*

Pharmacy Consultation Questionnaire

Qualifying Conditions (please check):

_____AIDS
_____Alzheimer's Disease
_____Chronic Traumatic Encephalopathy
_____Epilepsy
_____Glaucoma
_____Inflammatory Bowel Disease
_____Chronic Pain
_____HIV Positive
_____Sickle Cell Anemia
_____Tourette's Syndrome
_____Ulcerative Colitis
_____Amyotrophic Lateral Sclerosis (ALS)
_____Cancer
_____Crohn's Disease
_____Fibromyalgia
_____Hepatitis C
_____Multiple Sclerosis
_____Parkinson's Disease
_____Post-Traumatic Stress Disorder (PTSD)
_____Spinal Cord Disease
_____Traumatic Brain Injury

Additional Symptoms:

_____Pain (aching. Throbbing, treated with opiates)
_____Taper of Opiates/Discontinue Use
_____Insomnia/Sleep
_____Muscle Spasms
_____Cancer Fighting Effects
_____Neuropathy (Shooting and numbness)
_____Chemotherapy induced nausea
_____Tremor
_____Anxiety
_____Inflammatory Disorders

Other (Please Specify):

____
____
____
____

Additional Notes (allergies, upcoming surgeries, etc.):

____
____
____
____

What medications are the patient currently taking to treat symptoms/main complaints:

____
____
____
____

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