METRO MULTI-DISCIPLINARY DOCTORS
450 Lincoln Street Suite 104 Denver CO 80203
720-519-1236 TEL / 720-708-3172 FAX

Please Print Clearly in all spaces below	Today's Date:		
PATIENT INFORMATION			
Last Name:	First:	Middle:	
Social Security #:	**Birth date**: / /	**Age:**	**Sex**: • M • F
Cell phone #:	Home Phone #:		
Mailing Address Including City, State and Zip Code:			
Email:	Marital Status: Single / Married / Divorced / Other:		
Occupation:	Employer:		

How did you hear about us? Please check applicable box below.

- • Family/Friend • Website • The Westword • Facebook • Life on Capital Hill
- • Craigslist • Renewal letter • Rooster • Culture • 5280 Magazine

• Dispensary (please list): _____

• Other (please list): _____

EMERGENCY CONTACT

Local Friend or Relative: _____ Phone #: _____

Relationship to you: _____

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 at the time of service.
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.

Patient Signature:	Date Signed:

METRO MULTI-DISCIPLINARY DOCTORS
450 Lincoln Street Suite 104 Denver CO 80203
720-519-1236 TEL / 720-708-3172 FAX

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
450 Lincoln St #104
Denver, CO 80203

METRO MULTI-DISCIPLINARY DOCTORS
450 Lincoln Street Suite 104 Denver CO 80203
720-519-1236 TEL / 720-708-3172 FAX

Printed Name: _____

Patient Signature: _____ **Date:** _____

Current Employment: □ Part-time □ Full-Time □ Unemployed □ Retired □ Disabled

Type of job: _____

Have you been seen by a physician for the condition you are coming in for? □ Yes □ No

Are your medical records available if requested? □ Yes □ No

How do you rate your overall general health?
□ Excellent □ Very Good □ Average □ Fair □ Poor

Do you have any drug allergies? □ None □Yes, Please List _____

_____

Have you ever been diagnosed with Schizophrenia? □ Yes □ No

Are you currently using Cannabis? □ Yes □ No

What does Cannabis help you with? _____

Chief Complaint/Qualifying Condition: (please check ALL that apply)

□ Cancer □ Glaucoma □ HIV/AIDS □ Cachexia □ Persistent muscle spasms
□ Seizures □ Severe Nausea □ Severe Pain □ PTSD □ Autism Spectrum Disorder
Other: _____

Who is your current treating physician? _____

Diagnostics: (list any x-rays, MRI's, labs, studies, or tests performed)

_____

_____

Please list any chronic and serious illnesses:

_____

_____

Please list any hospitalizations:

Year	Illness/Operation	Residual effects

Please list any previous trauma: (example: automobile accident, work injury, sports injury, fall, fractures, strains, etc…)

Year	Injury/Accident	Residual effects

Please list ALL medications and dosages: (include supplements, prescription, and over the counter medications)

_____

_____

_____

METRO MULTI-DISCIPLINARY DOCTORS
450 Lincoln Street Suite 104 Denver CO 80203
720-519-1236 TEL / 720-708-3172 FAX

Previous treatments you have tried: (please circle all that apply)

Pain Killers Muscle Relaxants Anti-inflammatories Steroids Sleeping Pills Anti-Depressants
Ice/Heat Physical Therapy Pool Therapy Massage Acupuncture Chiropractic
Exercise Tens Unit Splints or Braces Hot Tub Orthotics TMJ Splint
Cane/Walker Wheelchair Marijuana Other: _____

Side effects of Medications: _____

Social /Habits / Family / Education:

Do you use: (please circle all that apply)

Tobacco Caffeine Alcohol Recreational Drugs

Have you ever been in an alcohol, drug, or mental illness program? □ Yes □ No

Exercise/Hobbies/Recreation: _____

Highest Education completed: _____

Marital Status: □ Single □ Married □ Divorced □ Separated

Number of Children: _____ Ages: _____

Are you pregnant? □ Yes □ No

If you are a woman of childbearing age, be aware that the use of medical marijuana during pregnancy may not be safe for the unborn child. MMD and its physicians recommend that you abstain from the use of medical marijuana if you are attempting to become pregnant. Failure to stop using medical marijuana if you become pregnant may result in complications in the unborn child or birth defects. **Signature X**_____

Family member's history: Does anyone in your family have/had? (circle all that apply)

Spine Problems Heart Disease Arthritis Diabetes Drug Abuse
Alcoholism Mental Problems Other: _____

Health Status of family members (ie: chronic health concerns)

	Age	Health Status (if deceased, list cause of death)
Father	_____	_____
Mother	_____	_____
Sibling	_____	_____
Sibling	_____	_____
Sibling	_____	_____
Sibling	_____	_____
Sibling	_____	_____

METRO MULTI-DISCIPLINARY DOCTORS
450 Lincoln Street Suite 104 Denver CO 80203
720-519-1236 TEL / 720-708-3172 FAX

Sibling _____ _____

Printed Name: _____

Patient Signature: _____ Date: _____

Consent for Evaluation of Patients Suitability for Use of Medical Marijuana

I, _____, believe that I have a debilitating medical condition as defined by the Colorado Medical Marijuana Amendment and have attempted to obtain copies of my pertinent medical records.

I understand that I am consulting with a physician at MMD for the sole purpose of an evaluation of my condition to obtain an opinion as to whether I may benefit from the use of medical marijuana to alleviate symptoms pertaining to my debilitating medical condition. The physicians at MMD who evaluate me will base their recommendation 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 medical 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 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 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 opinion is that I may benefit from medical marijuana, that recommendation 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 medical marijuana from any specific dispensary or caregiver.

By signing below, you agree that you have read, understand, and agree to the above marked items and statements.

Printed Name: _____

Patient Signature: _____ Date: _____

If you are under the age of 21, providers at MMD require medical records and may require the acknowledgement from a parent/guardian that you are utilizing medical marijuana to treat your qualifying condition.

METRO MULTI-DISCIPLINARY DOCTORS
450 Lincoln Street Suite 104 Denver CO 80203
720-519-1236 TEL / 720-708-3172 FAX

I, _____, believe that my child has a debilitating medical condition as defined by the Colorado Medical Marijuana Amendment, has the pertinent medical records, and may benefit from the use of medical marijuana to alleviate symptoms pertaining to the documented debilitating medical condition.

Printed Name: _____ Relationship to Patient_____
Parent/Guardian Signature: _____ Date: _____

Medical Marijuana Discharge Instructions

MMD conforms to and follows the law and constitution of the State of Colorado as well as the City and County of Denver. If our doctors have recommended medical marijuana for you, you must comply with the following:

New patients-
Patients applying to the registry for the first time via ***mail*** can purchase medical marijuana with a set of paperwork consisting of your Physician's Certificate, state application, a certified mailing receipt, and a valid picture ID. This may be used as a temporary card **at the dispensary's discretion**.

Patients applying to the registry for the first time via ***online*** can purchase medical marijuana with a set of temporary paperwork which is the completed application that can be printed from the "registration page" within your portal that states your application is "pending staff review", **at the dispensary's discretion.**

***Acceptance of any temporaries is at the discretion of the dispensaries and cannot be guaranteed by MMD staff.**

Renewal patients-
Patients renewing with the registry can only purchase up until the expiration date printed on your medical marijuana license. For patients whose medical license has already expired, you may only possess with your renewal paperwork. We do recommend that renewal patients prepare themselves for an extended lapse if renewal exam is done within 45 days of expiration.

1. Medical marijuana purchased from a dispensary or provided to you by a caregiver is for medicinal purposes only. You should not sell, give away, or otherwise distribute any medical marijuana.

2. You should only consume medical marijuana at your residence. It is not for use in public places. Medical marijuana is not to be used by persons under the age of 18 unless otherwise recommended by a physician.

Please be advised that your application will be denied if everything required by the State is not mailed or provided within your portal. If you are leaving our practice with incomplete paperwork, you must provide the following to complete your required paperwork:

Initial if you have missing information from your application and only initial next to the item you are missing.

- Full Social Security Number on application x_____
- Phone number on application x_____
- Address on application x_____
- Valid Colorado ID/Driver's License x_____
- Proper proof of residency (if you have an out-of-state license) x_____
- Caregiver information (if a caregiver is needed) x_____
- Certified mailing (for mail-in application only) x_____
- State fee (for mail-in application only) x_____
- Other (i.e.: Marriage License, Divorce Decree, etc.) x_____

Metro Multi-Disciplinary Doctors
450 Lincoln Street Suite 104 Denver CO 80203
720-519-1236 tel / 720-708-3172 fax

***If your application is returned because of an error made by the sender, we can help correct the issue, however a fee may apply.**

By signing below, you agree that you have read, understand, and agree to the above marked items and statements.

Patient Name: _____

Patient Signature: _____ Date:_____

Marijuana Usage Questionnaire

How often do you currently use marijuana?

o Occasional – less than 2x week		o Frequent – 2-5 days a week
o Regular – Daily use *Please answer →	Average number of uses daily?	o Not at all – I am new to marijuana. I have little to no tolerance for THC.

Please select your preferred method of usage. Select all that apply with X in the box

Flower	Concentrate	Tincture	Edibles	Topicals
Smoked or vaped	Smoked or vaped	Sublingual	Ingestion	Applied to skin

What is the approximate amount of each medication you use daily?

*Select any or all usage types and then select an option that best fits your amount consumed.

Flower	Concentrate	Tincture	Edibles	Topicals
o 1-3grams o 1/8oz o 1/4oz o 1/2oz +	o 1x Daily o 1-3x Daily o 3-5x Daily o 5-10x Daily o 10+x per Day	o 1-2mg o 2-5mg o 5-10mg o 10-50mg o 50mg +	o 1-2mg o 2-5mg o 5-10mg o 10-50mg o 50mg+	o 1x Daily o 1-3x Daily o More than 3x Day

METRO MULTI-DISCIPLINARY DOCTORS
450 Lincoln Street Suite 104 Denver CO 80203
720-519-1236 TEL / 720-708-3172 FAX

Conversion Chart:	Note:
1/8oz = 3.5grams 1/4oz = 7grams 1/2oz = 14grams 1oz = 28grams 1/8th of flower = 1gram concentrate = 100mg edibles.	Daily Totals are calculated by a total of THC milligrams. Your purchase can be any one type of medication or any combination not to exceed the daily allowed *total THC limit.*

Do you experience negative or adverse side effects from your current amount of usage?	o No
o Yes *Please explain	
Have you ever been too medicated and felt out of control?	o No
o Yes *Please explain	
Are you between the ages of 18-20 years old?	
o YES	o NO

By signing below, you agree and understand that this is a recommendation for medical marijuana. Medical marijuana affects each user differently due to varying factors that included but not limited to your inner cannabinoid system, your metabolism, how much and how often you use marijuana and the THC content as well as cannabinoids and terpenes within the product itself. The best of rule of thumb is to use the least amount of medication possible to gain the most benefits. As with any treatment there can be side effects. Side effects are covered in our Cannabis Usage Guide. This recommendation is not intended to override or replace any ongoing treatments that you have been placed in or on by a primary care provider or other specialist. You agree to use caution while driving, operating machinery and if you are in the direct position of care for any other individual.

Form completed by:	
o Patient	o Patient's Authorized Representative

METRO MULTI-DISCIPLINARY DOCTORS
450 Lincoln Street Suite 104 Denver CO 80203
720-519-1236 TEL / 720-708-3172 FAX

Patient's Signature: X_____	Relationship to Patient and Signature: X_____

Medical Marijuana Mental Health and Usage Screening

*Please answer the following questions to the best of your ability, be as honest as possible. This screening will address how, and how often you currently use marijuana. You will also be asked to answer mental health screening questions. This survey has been made necessary due CO Legislation, specifically HB21-1317.

Mental Health Screening

Do you suffer from, or have you ever been diagnosed with the following? *Please check all the boxes that apply to you.	YES	NO
Depression		
Anxiety		
PTSD		
Schizophrenia		
Bi-Polar/Manic Disorder		
Attempted Suicide		
Sleep Disorders *including but not limited to insomnia, inability to fall asleep, difficulties returning to sleep, sleep apnea etc...		
Dementia or Alzheimer's Disease		
Opioid Addiction		

METRO MULTI-DISCIPLINARY DOCTORS
450 Lincoln Street Suite 104 Denver CO 80203
720-519-1236 TEL / 720-708-3172 FAX

Alcohol Abuse		
Are you currently being treated or currently taking any prescribed medications, self-prescribed medications, herbs, or supplements for any of the above conditions? *If yes, please list and describe below.		