EUPHORIA WELLNESS

REGISTRATION FORM

(Please Print)

Today's date:			Registry ID Number:	
PATIENT INFORMATION				
Patient's last name: First:			❑ Male ❑ Female	❑Other: _____
Middle:			Birth date:	Age:
Street address:		Email:		Cell Phone: ( )
City:	State:	ZIP Code:		Are you a Veteran? ❑ Yes ❑ No *Military identification is necessary in order to receive a veteran's discount.*
Do you have a designated primary caregiver? □ Yes □ No	Designated Primary Caregiver First and Last Name:			Caregiver ID Number:
How did you hear about us? ❑ Dr. _____ ❑Family/Friend ❑ Walk-in ❑ Google ❑ Website ❑ Weedmaps ❑ Leafly ❑ Other _____				
May we notify you of any additional information on new strains as the information becomes available? □ Yes □ No				
ADDITIONAL INFORMATION				
(Please give your registry identification card to the receptionist.)				
Patient ID Number:	Issue Date:	Attending Physician:		Expiration date:
Symptoms:				
Is this your first time at Euphoria Wellness? ❑ Yes ❑ No				
The above information is true to the best of my knowledge. I also authorize Euphoria wellness to release any information required to the Maryland Medical Cannabis Commision. _____ _____ *Signature* *Date*				

OFFICE USE ONLY

Medical Marijuana Agent Name _____

Medical Marijuana Agent Registration Id number _____