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 Cannabis Agent Name _____

Medical Cannabis Agent Registration Id number _____