

Euphoria Wellness
Patient Registration Form

Today's Date:					
Patient's first name:		Middle:	Last:	Phone number ()	<input type="checkbox"/> CELL <input type="checkbox"/> HOME <input type="checkbox"/> WORK
Street address:			Email address:		
P.O. box:	City:	State:	ZIP code:	Preferred contact method: <input type="checkbox"/> CALL <input type="checkbox"/> EMAIL <input type="checkbox"/> TEXT <input type="checkbox"/> US MAIL	
Driver license or identification number:			Birth date: / /	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Medical marijuana patient ID number:				MMJ ID expiration: / /	
Physician name:			Physician	City:	State:
Designated caregiver:			Caregiver phone number: ()		
Diagnosis / Ailments:					
How did you hear about us? <input type="checkbox"/> Patient referral <input type="checkbox"/> Physician referral <input type="checkbox"/> Our website <input type="checkbox"/> Other, please specify _____					
Emergency contact:		Relationship:		Phone number ()	
The above information is true to the best of my knowledge. I also authorize Euphoria Wellness to release any information required to the Division of Public and Behavioral Health of the Nevada Department of Health and Human services.					
Signature:				Date: / /	
OFFICE USE ONLY					
Patient education materials provided: <input type="checkbox"/> Basic cannabis FAQs <input type="checkbox"/> Notice of privacy practices				Date: / /	
Medical marijuana agent name:			Medical marijuana agent ID number:		