Euphoria Wellness

Patient Registration Form

Today's Date:				
Patient's first name: Middle: Last:			Phone number ( )	□ CELL □ HOME □ WORK
Street address:			Email address:	
P.O. box:	City:	State: ZIP code:	Preferred contact method: □ CALL □ EMAIL □ TEXT □ US MAIL	
Driver license or identification number:			Birth date: / /	Sex: □ M □ 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? □Patient referral □Physician referral □Our website □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: □ Basic cannabis FAQs □ Notice of privacy practices	Date: / /
Medical marijuana agent name:	Medical marijuana agent ID number: