SAPHYRE

New Patient Intake Form

Curating Community Beyond Wellness

FIRST NAME | LAST NAME

NICKNAME / PREFERRED NAME & PRONOUNS *(she/her) (he/him) (they/them)*

GENDER

- € Female
- € Male
- € Nonbinary
- € Prefer Not To Say

DATE OF BIRTH | PHONE NUMBER

ADDRESS

Street

City | *State* | *Zip Code*

EMAIL ADDRESS

EMERGENCY CONTACT NAME & NUMBER

SAPHYRE

MEDICAL MARIJUANA IDENTIFICATION NUMBER

DRIVER'S LICENSE NUMBER *(Or associated ID number, i.e. passport number)*

ARE YOU REGISTERED WITH THE BOARD OF PHARMACY AS INDIGENT/VETERAN?

- YES
- NO

If YES, please list all that applies:

PRIMARY QUALIFYING CONDITION(S)

I understand that per the State of Ohio Board of Pharmacy requirements, my identification address MUST match the address on my medical marijuana registry. If this does not match, I will need to log into the registry and update the address before making a purchase. I also understand that I must present a physical copy of my license or passport. Digital pictures or printouts of my driver's license or passport are strictly prohibited and will not be accepted.

Print Name:

Signature: