SAPHYRE New Patient Intake Form

FIRST NAME	LAST NAME

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

GENDER: Circle: Female Male Nonbinary Prefer Not to Say

DATE OF BIRTH	PHONE NUMBER

ADDRESS *Street*

City *State* *Zip Code*

EMAIL ADDRESS

EMERGENCY CONTACT NAME & NUMBER

CAREGIVER CONTACT NAME & NUMBER (IF APPLICABLE)

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? Circle: YES NO

If YES, please list all that applies:

PRIMARY QUALIFYING CONDITION(S)

I understand that per the Ohio Division of Cannabis Control 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. <u>Digital pictures or printouts of my driver's license or passport are strictly prohibited and will not be accepted</u>.

SIGNATURE	**DATE**