New Patient Registration

Last Name: _____ First Name: _____

Middle Initial: _____

Email: _____ Date of Birth: _____

Phone: _____ Cell / Home (circle one)

Do we have permission to send you text updates? Yes / No (circle one)

Do we have permission to call you when necessary? Yes / No (circle one)

Address: _____

_____

Medical Cannabis Patient ID #: _____

Expiration Date: _____

Recommending Physician: _____

- **What products interest you? Please check all that apply.**
  Flower___ Concentrates___ Oils ___ Topicals ___ Other _____
- **Are you a veteran?**
  Yes ___ No ___
- **Are you a senior citizen (55 or over)?**
  Yes ___ No ___
- **How did you hear about us?**
  Google ___ Leafly___ Weedmaps ___ Referral ___ Other_____
  Referral Name: _____

GROW WEST

EST. 2016

CANNABIS COMPANY

Conditions(s) / Symptom(s):

Allergies:

Experience Level with Cannabis (circle one):

No Experience (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) Experience

Describe cannabis knowledge (optional):

List Hobbies (optional):