

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 (      )
<b>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.</b>			
Signature:		Date: /      /	
<b>OFFICE USE ONLY</b>			
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:	