11890 Kinsman Road
Newbury, OH 44065

Consent to Treat

I voluntarily consent that Dr Richard Silver and other clinical personnel of Medical Marijuana Physicians of Ohio at Silver Lake Wellness Center be permitted to evaluate and treat me for the conditions for which I present myself to this office.

I acknowledge that I am legally responsible for all charges in connection with the medical care and treatment provided by Dr Richard Silver.

I understand that this consent form will be valid and remain in effect as long as I receive my medical care at Medical Marijuana Physicians of Ohio at Silver Lake Wellness Center. I also understand that this consent may be revoked in writing at any time.

Patient Name: _____ Date: _____

Patient Signature: _____

Medical Marijuana Physicians of Ohio
At Silver Lake Wellness Center

Informed Consent

11890 Kinsman Road
Newbury, OH 44065

MEDICAL MARIJUANA INFORMED CONSENT

1. Patient or caregiver has requested a recommendation from Dr Richard Silver for medical marijuana pursuant to Ohio state law.
2. Cannabis use has not been analyzed or approved by the FDA. While states such as Ohio have been allowed to legalize marijuana use for qualified medical conditions, it is illegal federally, therefore, it is a crime to possess marijuana on federal land such as national parks, federal buildings, and maybe federally subsidized housing. Please consult an attorney if you have other legal concerns.
3. There may be health risks associated with cannabis use. Patient or caregiver holds Dr Silver, Medical Marijuana Physicians of Ohio (MMP Ohio), and Silver Lake Wellness Center harmless for adverse outcomes associated with marijuana use. If adverse effects occur, I will discontinue use and contact Dr Silver.
4. Medical cannabis is intended only for the patient and should not be diverted or shared. Please keep this medicine away from children.
5. Patients are warned not to drive an automobile or operate other equipment while under the influence of marijuana.
6. Patient or personal caregiver assume the risk of potential harm caused by cannabis including low blood pressure, loss of balance, drowsiness, slower reflexes, aggravation of pre-existing mental or physical disorders, injuries, and addiction.
7. Patient agrees to comply with all statutes and rules regarding cannabis use including Ohio House Bill 523.
8. Marijuana patients/caregivers acknowledge that obtaining an Ohio marijuana registration card allows purchase of up to 90 days supply of marijuana, and protects persons from arrest for possessing legal quantities. However, the “Card” does not protect patients from consequences where employment forbids it's use, or where state law forbids impairment, such as operating a motor vehicle.
9. While Dr Silver will monitor your progress for the qualifying condition that you are treated today, he does not provide primary medical care; therefore patient agrees to consult a primary care doctor for other health concerns.
10. Patient agrees not use marijuana while pregnant or breast-feeding.
11. I CERTIFY THAT I HAVE READ THIS ENTIRE AGREEMENT AND I AM SIGNING BELOW OF MY OWN FREE WILL.

NAME _____ DATE _____

_____ _____

Signature of patient or caregiver Witness

Medical Marijuana Physicians of Ohio
At Silver Lake Wellness Center

Patient Intake Form

11890 Kinsman Road
Newbury, OH 44065

Date: _____ D.O.B. _____

Name: _____ Sex: ____ M ____ F

E-mail address: _____ Phone # _____ May we text you? __

Street Address: _____

City: _____ State: _____ Zip: _____

State Issued ID: Identification # _____ Marital Status: _____ #Children: _____

Employment/Occupation: _____ Are you a Veteran? _____

Primary Care Physician: _____ Are you on Medicare? _____

Are you on Permanent Disability? _____

Emergency Contact:

Name: _____ Phone # _____

ALLERGIES:

Who referred you to this office? _____

Medical Marijuana Physicians of Ohio
At Silver Lake Wellness Center

Patient History

11890 Kinsman Road • Newbury, OH 44065
440-832-7009 • mmpohio.com • info@mmpohio.com

Name: _____ Date: _____

CHIEF COMPLAINT & HISTORY OF CHRONIC CONDITION

_____

_____

_____

_____

_____

_____

_____

PAST MEDICAL DISEASE HISTORY

"X" next to condition or disease you have been treated for:

___ AIDS/HIV
___ ALS
___ ALZHEIMER'S
___ CANCER
___ CHROINIC TRAUMATIC ENCEPHALOPATHY
___ EPILEPSY
___ FIBROMYALGIA
___ GLAUCOMA
___ HEPATITIS C
___ IBD
___ ASTHMA
___ COPD
___ HEART DISEASE
___ KIDNEY DISEASE
___ HIGH BLOOD PRESSURE
___ DIABETES
___ MS (MULTIPLE SCLEROSIS)
___ PAIN (CHRONIC OR INTRACTABLE)
___ PARKINSON'S DISEASE
___ PTSD
___ SICKLE CELL ANEMIA
___ SPINAL CORD DISEASE OR INJURY
___ TOURETTE'S SYNDROME
___ TRAUMATIC BRAIN INJURY
___ ULCERATIVE COLITIS
___ CROHN'S DISEASE
___ NEUROLOGIC DISEASE
___ STROKE
___ LIVER DISEASE
___ ANXIETY/DEPRESSION/BIPOLAR
___ BLOOD DISEASE
___ HORMONE DISORDER

HISTORY OF SUBSTANCE USE DISORDER:

_____

OTHER MEDICAL PROBLEMS NOT LISTED:

_____

Medical Marijuana Physicians of Ohio
At Silver Lake Wellness Center

Patient History

11890 Kinsman Road • Newbury, OH 44065
440-832-7009 • mmpohio.com • info@mmpohio.com

Name: _____ Date: _____

VITAMINS or SUPPLEMENTS

_____

_____

_____

_____

_____

_____

_____

MEDICATIONS

_____

_____

_____

_____

_____

_____

_____

PAST SURGICAL HISTORY

"X" next to any surgical procedure you have received:

___ past concussion or brain injury
___ past bone fractures
___ other abdominal surgery
___ heart surgery
___ lung or other thoracic surgery
___ joint or bone surgery
___ joint replacement
___ back surgery
___ kidney surgery
___ skin surgery
___ Tonsillectomy
___ appendectomy
___ gall bladder surgery
___ hysterectomy
___ ovaries removed
___ urinary bladder surgery
___ vaginal surgery

PREVENTATIVE HEALTH HISTORY

Last Physical Exam: _____ Last Blood Test: _____
Last Dental Exam:_____
Last Colonoscopy:_____ Last Chest X-ray:_____
Last Eye Exam: _____
Last Full Body Skin Cancer Screening: _____
Men Last Digital Prostate Exam: _____

Women Pregnancies:_____ Live Births: _____
Last Menstrual Period: _____ Last PAP or Pelvic Exam: _____
Last Mammogram: _____
Last Bone Mineral Density (DEXA): _____

Medical Marijuana Physicians of Ohio
At Silver Lake Wellness Center

Patient History

11890 Kinsman Road • Newbury, OH 44065
440-832-7009 • mmpohio.com • info@mmpohio.com

Name: _____ Date: _____

Have you used marijuana (cannabis) in the past? ____

What effects did the marijuana have on you? _____

_____

Did you have any adverse reactions? _____

QUALIFYING CONDITIONS

Mark your Qualifying Condition with an "X" if you are applying for "**MEDICAL MARIJUANA CARD**"
You must be an OHIO resident to qualify for an OHIO MEDICAL MARIJUANA CARD.

___ AIDS/HIV
___ ALS (AMYOTROPHIC LATERAL SCLEROSIS)
___ AD (ALZHEIMER'S DEMENTIA)
___ CANCER
___ CACHEXIA
___ CROHN'S DISEASE
___ CTE (CHRONIC TRAUMATIC ENCEPHALOPATHY)
___ EPILEPSY/SEIZURES
___ FIBROMYALGIA
___ GLAUCOMA
___ HEPATITIS C
___ HUNTINGTON'S DISEASE
___ IBD (INFLAMMATORY BOWEL DISEASE)
___ MS (MULTIPLE SCLEROSIS)
___ PAIN (CHRONIC OR INTRACTABLE)
___ PD (PARKINSON'S DISEASE)
___ PTSD (POST TRAUMATIC STRESS DISORDER)
___ SICKLE CELL ANEMIA
___ SPASTICITY
___ SPINAL CORD DISEASE OR INJURY
___ TERMINAL ILLNESS
___ TOURETTE'S SYNDROME
___ TBI (TRAUMATIC BRAIN INJURY)
___ ULCERATIVE COLITIS

What previous treatment have you tried for the condition for which you will use marijuana? And what response do you have with previous treatment?

_____