Behm Family Practice, LLC

2500 Brooktree Rd., Suite 200, Wexford, PA 15090
Phone 724-940-0300 Fax 724-940-0301

PATIENT REGISTRATION FORM FOR MEDICAL MARIJUANA CERTIFICATION
Please Print

Last Name:____________________________

First Name:____________________________

Middle Name:__________________________

Other names used:_____________________

Address 1:_____________________________

Address2:______________________________

City:__________________________________

State:________Zip Code:_________________

Date of Birth:__________________________

Sex: M or F other___________

Mobile Phone:_________________________

Home/Other Phone:_____________________

Patient Email: ___________________________

Required by Government Mandate:

Primary Language:_______________________

Race:__________________________________

Marital Status: __________________________

Sexual preference: Heterosexual, Homosexual, Bisexual, Other ____________________

Assigned Sex at birth: Male Female

Pronouns: he/him she/her they/them

Contact Preferences: Home Phone, Mobile Phone, Patient Portal, other _________________________

Emergency Contact

Name:____________________________________

Relationship:_______________________________

Phone: ____________________________________

ACKNOWLEDGEMENT AND AUTHORIZATION: Please sign

To the best of my knowledge the above information is complete and accurate.

Sign Name: _______________________________

Relationship to patient:*(Required if someone other than patient is completing this form.)*

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- **I have read and understand the HIPAA/Privacy Policy and Financial Policy for Behm Family Practice, LLC**

  Signed____ **Date:**_______________

- **I authorize Behm Family Practice, LLC to obtain/have access to my medication history and share medical history with connected at connected care locations.**

  Signed____ **Date:**_______________

- **I authorize Behm Family Practice, LLC to take my photograph or import my photo from my drivers license or photo ID to add to my patient chart for identification.**

  Signed____ **Date:**_______________

Provide a copy of the front and back of your drivers license with this registration form if mailing this form to our office or present it to the receptionist at your appointment along with a valid drivers license or state ID card.