Welcome Back to Southwest Medical Marijuana Evaluation Center!

We appreciate your loyalty and trust in us for your medical needs

Just a few reminders:

- **Your appointment**
  - This packet contains paperwork that needs to be completed. If you do not get a chance to complete it prior to coming in for your appointment, please arrive 15 minutes early to do so
  - Please make sure you bring an **Az State issued driver's license, state ID or Valid US passport** with you. In addition, if you are on the **SNAP** program, please bring your card or approval letter if your card does not have your name on it
  - Your appointment time with the doctor will be approximately 15 – 20 minutes. Your total time at the office will be approximately 45 minutes – so plan accordingly. If we are running later than that we will advise you at check in
  - Your appointment will be with an Arizona state licensed physician
  - During your appointment your physician will review any new medical history related to your qualifying condition (if it exists) and assess the benefits and adverse effects (if any) of the use of cannabis over the past 10-12 months. In addition, other treatment options the physician feels would assist you will be recommended.
- **What's Next?**
  - Once you have completed your appointment with your physician, you will go through the checkout process with one of our knowledgeable staff who will take your photo and documentation necessary for us to process your application with the state. After your application has been approved by the state (up to 5-day process), in approximately 10 business days you will receive your renewal card in the mail
  - If your current card expires prior to receiving the new one, you will not be able to purchase medicine from a dispensary until the new one arrives. This is why we highly encourage patients to make sure they leave enough time for the renewal process.
  - As you know, an annual renewal is required, so approximately 10 months from your appointment, you will receive an email reminding you it is time to come back in. If you have been to another physician and/or chiropractor for your qualifying condition since we saw you last, your physician will want to review those records. Please complete a records release to start this process.
- **Other services**
  - Each of our physicians at SWMMEC specialize in different areas in addition to the recommendation of cannabis. Therefore, at the time of your appointment, your physician may recommend other very important treatment options for you that may include supplements and follow up care. Follow up appointments can be scheduled during the checkout process.

Our mission is to provide the medical marijuana patient with dignity, professionalism, confidentiality and compassion

Southwest Medical Marijuana Evaluation Center

Follow up Health Questionnaire

Personal Information:

Any changes to your Address, Phone # or Email Address since your last visit? YES NO

If so, please indicate new information: ____

____

____

Medical History

Current Prescription Medications: **include the strength and dosing instructions**

____

____

____

Current Non Prescription and Supplements:____

____

____

Any major changes to your health since last visit: YES NO

If so, indicate what ____

____

____

Any Hospitalizations and/or **Surgeries since last visit:** YES NO

If so, indicate reason and, dates: ____

____

____

Medical Marijuana (MMJ) History

Do you use MMJ to reduce or eliminate the use of any medications that have been prescribed for your medical condition? Yes/No If yes, which medication have you reduced or eliminated and why? ____________________

____

____

How often do you use MMJ ? ( ) ____ x day ( ) ____ x/ week ( ) _____ x/month

What is your preferred method of using MMJ? ( ) smoke ( ) vaporizer ( ) ingested ( ) topical ( ) tincture

How effective is MMJ for your medical problem? ( ) very effective ( ) effective ( ) only somewhat effective

How does MMJ improve the quality of your life? ____

____

Additional Information
Do you have an open court case regarding marijuana? Yes / No Are you currently on probation? Yes / No

Please provide any additional information that may be relevant for your physician to know:
____
____
____

I understand that the information I have been asked to provide is for the diagnosis and treatment of the medical condition for which I am seeing the physician today and, if I have not accurately and completely disclosed the requested information, it may adversely impact the physician's ability to diagnose my condition and recommend appropriate treatment. I certify that the information in this questionnaire is accurate and complete and has been offered only for the purpose of gaining treatment of my medical condition. I further certify that I am not seeking marijuana for illegal purposes; I am not a reporter or member of the media working on a story; And, I am not a member of law enforcement seeking to investigate or build a case against my physician or anyone affiliated with my physician.

________________________________ ____________________
Patient Signature Date

____
Print Name

Az Department of Health Services Patient Application Form

(PLEASE **WRITE CLEARLY** / AN INPUT ERROR WILL DELAY YOUR CARD AND COST YOU ADDITIONAL $)

The information on this form will be used to process your application with the state.

Medical Marijuana Renewal Information

(New patients leave this section blank)

Current Az Registry Card #: ____ Exp Date: _____________

Driver's License / State ID Information

Az Driver's License #: ___________________________ **OR** Az State Identification #: ___________________________

DOB: ____/______/________Issue Date: _____/_______/______

Patient Information

First Name: ___________________________________ Last Name: ____

Mailing Address: ____ City:____________________________

State: _______________________ Zip Code: __________________________

EMAIL (required): ____ Best Phone Contact #: ______________________

Note: The state requires a street address when using a PO Box – please supply or your application will be delayed

Caregiver Information

(Only complete this section if you plan on having a MMJ caregiver - $200 additional fee required)

Date of Birth: _____________ Gender: ___________

First Name: __________________________ Last Name: ____

Address: ____

Zip Code: _________ City: ________________ County: _______________ State: __________

Other

You must select Yes or No – DO NOT LEAVE THIS SECTION BLANK

*Food Stamp Discount: Yes_____ No_____ / Cultivation privileges: Yes_____ No_____ / Homeless: Yes_____No_____

*must have a food stamp card w/your name on it, or, your eligibility letter in your name in order to get the state's discount fee of $75

I give my permission for SWMMEC to process my state application for a Medical Marijuana ID Card. In addition, I agree that the above information is accurate. If the application can't be processed due to illegibility, **I may be responsible for an additional fee of $20 to re-run the application.**

Signature: _______________________________________ Date: ___________________________

Print Name: _______________________________________

Note: This document will be destroyed once the application process with the state has been completed. Contact the office if you need your application ID # for any reason. The application ID # starts with AZQP….

Print Form

ARIZONA DEPARTMENT OF HEALTH SERVICES

MEDICAL MARIJUANA PROGRAM

MEDICAL MARIJUANA PATIENT ATTESTATION

I, ________________________________, attest that:

I will not divert marijuana to any individual who or entity that is not allowed to possess marijuana pursuant A.R.S. Title 36, Chapter 28.1 and that the information provided in the application is true and correct.

______________________________ ______________________________

Signature Date Signed