Patient Intake Form

*DISCLAIMER: This form must be filled out to **COMPLETION**. Information provided on this form is **REQUIRED** for your OMMA application. A Better Bloom Health and Wellness **DOES NOT KEEP PATIENT INFORMATION** after application submission.

DATE___/___/___ SITE LOCATION_____OR VIRTUAL_____

Check ONE New Patient_____ OR Renewal_____ If RENEWAL write license expiration date _____/_____/_____

DRIVERS LICENSE/STATE ID/PASSPORT INFORMATION (OMMA Does NOT Accept out of state ID's)

NAME (How it appears on your license) First_____MI_____Last_____
DATE OF BIRTH_____/_____/_____
STREET ADDRESS ON ID_____
CITY _____STATE_____ZIP _____COUNTY_____
DRIVERS LICENSE, STATE ID, OR PASSPORT NUMBER_____
LICENSE/ID/PASSPORT EXPIRATION DATE ___/___/_____

MAILING
Check ONE My mailing address is the same as my ID_____ My mailing address is different from my ID_____
MAILING ADDRESS (If different from ID)_____
CITY_____STATE _____ZIP CODE_____COUNTY_____

OMMA INFORMATION
If you are NOT registered with OMMA check HERE_____

EMAIL_____

PASSWORD_____

CONTACT INFORMATION (This MUST be valid)
PHONE NUMBER _____CELL PHONE NUMBER_____
EMAIL_____

PAYMENT INFORMATION Note: We do NOT accept American Express
CIRCLE ONE: DEBIT CARD / CREDIT CARD / PRE-PAID CARD
CARD NUMBER _____
EXPIRATION DATE___/____/_____ CVV CODE_____
ZIP CODE _____NAME ON CARD _____

INSURANCE INFORMATION CHECK IF APPLIES
Note: Proof of Medicaid, Medicare, or Sooner Care must be presented at time of appointment. Valid proof must be documentation issued by the Oklahoma Health Care Authority such as a card, or a screenshot of your online account.
MEDICARE_____MEDICAID_____ SOONERCARE _____
Group Number_____

Medical Information Form

Name: First_____ MI_____ Last_____
Age: _____
Sex: Male _____ Female_____ Other_____
Are you pregnant? YES ____ NO ____ UNSURE_____N/A_____
Are you breast-feeding? YES____ NO____ N/A____
Allergies? YES ___ NO___
List Allergies_____
Tobacco use: YES ___ NO____ TYPE _____ HOW OFTEN? _____
Alcohol use: YES ____ NO_____ HOW OFTEN? _____
What condition(s) do you want to treat with medical cannabis?

_____
_____

How long have you had these condition(s)?

_____

Please list any prescription medication you are <u>currently</u> taking for your condition(s) below:

_____
_____

List any previous treatments for these condition(s). Have they helped you?

_____
_____

How have these condition(s) impacted your daily life? Have they progressed?

_____
_____

Why do you want to use medical cannabis to treat the following condition(s)?

_____
_____

Telemedicine Consent Form

1. The purpose of this form is to obtain your consent for a telemedicine consultation with a physician. The purpose of this consultation is to assist in the diagnosis and treatment of: (List your top three conditions below)

   1. _____ 2. _____ 3. _____

2. Telemedicine involves the use of audio, video, or other electronic communications to: interact with you, consult with your healthcare provider (our physician), and or review your medical information for the purpose of your consultation please initial here_____
3. Any of the patient identifiable images or information from the telemedicine consultation shall not occur without your consent please initial here_____
4. All existing confidentiality protections apply to information used or disclosed during your telemedicine consultation please initial here_____

A Better Bloom Health & Wellness has disclosed with me the information provided above. I have had the opportunity to ask questions about this information and all my questions have been answered. I have agreed to a telemedicine consultation.

Patient Signature_____ **Date**_____