

## Nar Reserve Patient Information Form

Name of Patient (*First and Last*): \_\_\_\_\_

Date of Birth (*MM/DD/YYYY*): \_\_\_\_\_

Patient Registry ID #: \_\_\_\_\_ EXP Date: \_\_\_\_\_

Patient Driver's License #: \_\_\_\_\_ EXP Date: \_\_\_\_\_

Recommending Physician: \_\_\_\_\_

Current Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Gender: M \_\_\_\_\_ F \_\_\_\_\_ Other: \_\_\_\_\_ Pronouns: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Caregiver Name (If applicable): \_\_\_\_\_ Phone Number: \_\_\_\_\_

Caregiver Registry ID #: \_\_\_\_\_

Caregiver Address, City, State, Zip Code: \_\_\_\_\_  
\_\_\_\_\_

Are you Patient/Caregiver registered as:

\_\_\_\_\_ Indigent Status \_\_\_\_\_ Veteran Status \_\_\_\_\_ Terminal

Have you used cannabis before? Yes \_\_\_\_\_ No \_\_\_\_\_ If so, what is your experience with it? (*Check box that applies*)

A few times in your life  A few times a year  A few times a month  Weekly  Daily

What type of medical cannabis (marijuana) are you interested in? (*Circle all that may apply*)

Vaporizing Oils/Extracts    Tinctures    Plant Material    Edibles    Lotions/Creams    Patches

Do you have any allergies or are you prescribed any medication(s) with adverse reactions to MMJ products that we should be aware of? This could include chocolate, grapefruit, nuts, etc:

Yes \_\_\_\_\_ No \_\_\_\_\_ Unsure \_\_\_\_\_ If so, please list here \_\_\_\_\_

How did you hear about us?

\_\_\_\_\_ Medical Marijuana Control Program Website

\_\_\_\_\_ Referral:

\_\_\_\_\_ Patient

\_\_\_\_\_ Physician

\_\_\_\_\_ Employee

\_\_\_\_\_ Other: \_\_\_\_\_

## Nar Reserve Patient Information Form

### Patient Waiver of Liability and Hold Harmless Agreement

I, \_\_\_\_\_, acknowledge and understand the potential risks associated with acquiring and using approved medical marijuana products from Nar Reserve (Dispensary) for any purpose, whether medical or not. I am aware that there may be unknown risks and hazards associated with such products, and I take full responsibility for any potential loss, damage, or personal injury, including death, that may result from my possession or use of marijuana.

Furthermore, I agree to indemnify and hold harmless Dispensary, its affiliates, officers, directors, agents, representatives, and employees against any damages, liabilities, obligations, penalties, fines, judgments, claims, deficiencies, losses, costs, and expenses, including attorneys' fees and costs, that may arise from my relationship with Dispensary, my possession or use of marijuana, or any other controlled substance.

I confirm that this Waiver of Liability and Hold Harmless Agreement (Release) also applies to my family members, spouse (if applicable), heirs, assigns, and personal representative, and I intend for it to be considered a release, waiver, discharge, and covenant not to sue Dispensary or any of its affiliates, officers, directors, agents, representatives, and employees.

By signing this Release, I affirm that I have read and fully understand the terms outlined above, and I have not received any oral or written statements or inducements apart from what is outlined in this agreement. I am at least 18 years old, fully competent, and sign this Release voluntarily and with the intent to be bound by its terms. I also confirm that I have followed all applicable regulations set forth by the Ohio Board of Pharmacy in regards to the acquisition, possession, and use of medical marijuana, including obtaining a valid State-Issued Registry Identification Card. Dispensary can rely on this Release for the provision of any services or products to me.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Agent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*\*In the event a patient is under 18 years old, a legal guardian must execute this Release on the behalf of the Patient*