



Patient Information

First Name: _____ Last Name: _____
Date of Birth: _____ Sex: Male Female
Address: _____
City: _____ ZIP: _____
Phone Number: _____ Email: _____

Caregiver Information (if applicable)

First Name: _____ Last Name: _____
Date of Birth: _____ Sex: Male Female
Relationship to Patient: _____
Phone Number: _____ Email: _____

Contact Preferences

Preferred method of contact: Phone Email Text
Sign-up for Keystone Shops Newsletter: Yes No
Would you like to receive follow-up from Keystone Shops medical professionals: Yes No
How did you hear about Keystone Shops?
 Doctor Referral Online Search Social Media Community Events Newspaper
 Other _____

Qualifying Condition(s)

Please list the qualifying condition(s) your doctor has recommended medical marijuana use for:

Current Medication(s) / Allergies

Please list your current medication(s) and allergies:

Cannabis Experience (Past Year)

Never None in past year CBD Only Daily Weekly Monthly

What symptoms would you like medical marijuana to relieve?

Nerve Pain Muscle Pain Appetite Sleep Nausea Seizures

Other _____

Desired Use

Morning Noon Afternoon Evening Bedtime

Desired Psychoactivity (Euphoric feeling from medical marijuana)

None Low Medium High

Other Conditions (check that apply)

History psychosis/schizophrenia Pregnant/Breast Feeding
 Allergy to cannabis Unstable heart disease

Acknowledgement

1. Cannabis is a Schedule 1 Controlled Substance. According to Federal law, it is unlawful to board a plane, cross state lines, or be on any federal land while in possession of cannabis products.
2. Under Pennsylvania law, it is unlawful to transfer, divert, or allow the use of, cannabis to anyone else, even another medical cannabis patient.
3. I understand that while my status as a patient is protected under HIPAA privacy protections, medical cannabis patients are not necessarily protected from being terminated by employers with zero drug tolerance policies if they are discovered to be using cannabis.
4. I understand that a record will be made of my purchases at Keystone Shops Dispensary ("Dispensary") and this data will be shared with State regulatory bodies.
5. I understand that I am subject to camera surveillance and recording while on the Dispensary premises.
6. I acknowledge Keystone Shops may call me (and leave a voicemail if necessary) for non-promotional purposes only.
7. I understand that using medical marijuana will impair my ability to drive a motor vehicle or operate machinery and that it is illegal to drive under the influence of medical marijuana.

Patient hereby agrees to indemnify and hold harmless the Dispensary from and against all claims, demands, damages, costs, injuries, or expenses arising out of or in any way connected with the use or misuse of medical marijuana purchased at the Dispensary including any adverse side-effects, allergic reactions, ineffectiveness, or results stemming from the use of medical marijuana.

Signature

Date

Printed Name