**Patient Registration Form - Medical Marijuana Certification**

Please fill out, print and bring this form to your visit.

**Patient Name:** Click here to enter text. **Date of Birth:** Click here to enter a date.

**Preferred Name:** Click here to enter text.

**Phone Number:** Click here to enter text.

**Social Security Number (Required for Certification Form):** Click here to enter text.

**Address:** Click here to enter text.

**Emergency Contact: (Name and Phone#):** Click here to enter text.

Please read the following attachment of Harrisonville Family Medicine’s HIPAA and Privacy Practices and sign acknowledgement of receipt.

**I have read and understand the HIPAA/Privacy policy for Harrisonville Family Medicine, Inc.**

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Signature Date