Patient #:_____

New Patient Application

Patient Information		
Name:		
Address:		**City/Town:**
State: Massachusetts	**Zip Code:**	**D.O.B.**
Telephone No. ( ) -		**Date:**
Physician Information		
Name:		**DEA No.**
Address:		**City/Town:**
State: Massachusetts	**Zip Code:**	**Telephone No. ( ) -**
Card Issued:		**Card Expires:**

Medical Conditions: (Check all that applies)

____ Cancer	____ HIV/AIDS	____ Hepatitis C
____ Nausea	____ PTSD	____ Cachexia
____ Parkinson's disease	____ Glaucoma	_____ ALS
____ Multiple Sclerosis	____ Cohn's Disease	_____Other

Additional Comments:

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Patient Signature: _____Date: _____/_____/_____

Caregiver Signature: _____ Date:_____/_____/_____