OLIVE TREE
PATIENT ASSOCIATION

New Patient Intake Form:

Fill out the following sections and return the completed form to the Patient Coordinator.

Personal Information:

LAST NAME:	FIRST NAME:	MIDDLE NAME:
STREET ADDRESS:		
CITY + COUNTY:	STATE:	ZIP CODE:
MOBILE PHONE #:	EMAIL:	
DATE OF BIRTH:	GENDER:	

How did you hear about **Olive Tree Patient Association**? *Circle one or fill in:*

GOOGLE	WEEDMAPS	LEAFLY	BILLBOARD	FACEBOOK	MASSROOTS
TWITTER	DROVE OR WALKED BY	FRIEND:_____		OTHER:_____	

Would you like to receive specials and coupons via **email**? YES NO
Would you like to receive specials and coupons via **text**? YES NO

By checking "YES" Olive Tree Wellness Center may send you text messages. Any text messages sent are subject to standard text messaging rates determined by your mobile phone carrier. Standard text messaging rates may apply, as well as any monthly plan limits. Please be aware that texting charges can fluctuate internationally. Please contact your carrier and/or plan documents for your text messaging rates and limits.

This Section is For Collective Staff Use Only*

PATIENT'S PHYSICIAN'S NAME:	PHYSICIAN'S CA MEDICAL LICENSE #:	
HHSA QUALIFIED PATIENT IDENTIFICATION CARD #:		EXPIRATION DATE:
HHSA PRIMARY CAREGIVER ID CARD #:		EXPIRATION DATE:
PHYSICIAN'S RECOMMENDATION VERIFIED BY:		EXPIRATION DATE:
PCG DESIGNATION/RECOMMENDATION VERIFIED BY:		DATE:
PATIENT RECOMMENDATION: WRITTEN	HHSA ID CARD	VERBAL
STAFF SIGNATURE:	DATE:	