



SOUTHERN OHIO BOTANICALS

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Waverly, OH 45690
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southernohiobotanicals.com

New Patient Questionnaire

Date: ____/____/____

Name: _____

Date of Birth: ____/____/____

Address: _____

City: _____ State: ____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Medical Marijuana Card Number: _____

Drivers License Number: _____

Do you have a licensed Caregiver(s)? Yes _____ No _____

Your designated caregiver(s) who is registered with the state Medical Marijuana Program.

Caregiver's Name: _____

Caregiver's ID Number: _____

Caregiver's Name: _____

Caregiver's ID Number: _____

Are you a Veteran? Yes _____ No _____

Indigent Status? Yes _____ No _____

Rate your experience with Medical Marijuana: Please Circle

No Experience Some Experience Very Experienced

We know you may have questions. Would you like a consultation with a Patient Care Technician today? Yes _____ No _____

Which products are you interested in?

Flower _____ Concentrates _____ Edibles _____
Tinctures _____ Vaporizer Pens _____ Salves _____

How did you hear about Southern Ohio Botanicals?

Family/Friend _____ Website _____ Physician _____
Internet Search _____ Other _____

Would you like to receive emails/texts regarding sales and promotions? Yes _____ No _____

In the event the dispensary is unable to dispense medical marijuana products what is your preference for communication of such an event?

Phone Call _____ Text Message _____ Email _____

Signatures

Patient/Caregiver's
Printed Name:

Patient/Caregiver's
Signature:

Date: ____/____/_____

