SUN VALLEY
CERTIFICATION CLINIC

MEDICAL MARIJUANA CARD HOLDER REGISTRY ACCOUNT

I hereby acknowledge that I give permission for Sun Valley Certification Clinic to assist me in the uploading of my Nevada medical marijuana card application by assisting me in creating, accessing and modifying my Medical Marijuana Card Holder Registry account. I understand that Sun Valley Certification will use the information on this page only for assisting me in the creation of my Nevada Card Holder Registry account. I desire my email and password to be the following:

____
Name of Patient (please print)

Is your mailing address different than the one listed on your id? ☐ YES ☐ NO
If yes, what is your new address? ____

____
Patient Email (the state will use this email to contact you with your approval information)

__ __ __ __ __ __ __ __ __ __ __ __ __ _____________________________________
Password (12 character requirement) **Social Security Number of Patient**

Do you wish to name a caregiver on your application? ☐ YES ☐ NO

____ ____________________
Patient Signature **Date**

When approved by the state, you will receive an email with a link to the patient portal. Use your driver's license number and the password above to access your account. If you have any difficulties or questions, we will assist you. Just call us at 702-420-2205. We're here to help!

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PATIENT INTAKE FORM

NAME: _____ DATE OF BIRTH _____
LAST FIRST MIDDLE

ADDRESS: _____
ADDRESS APT # CITY STATE ZIP

PHONE: _____ EMAIL: _____
CAN WE LEAVE A MESSAGE ON YOUR PHONE: ☐ YES ☐ NO DO WE HAVE YOUR PERMISSION TO EMAIL YOU (APPOINTMENT INFORMATION AND SPECIALS)? ☐ YES ☐ NO

HOW DID YOU LEARN ABOUT US? _____

ARE YOU A VETERAN? ☐ YES ☐ NO
ARE YOU CURRENTLY PREGNANT OR BREASTFEEDING? ☐ YES ☐ NO
ARE YOU RENEWING A CURRENT NEVADA MEDICAL MARIJUANA CARD? ☐ YES ☐ NO
ARE YOU A PREVIOUS PATIENT OF OURS? ☐ YES ☐ NO

PLEASE LIST THE PRIMARY HEALTH PROBLEMS THAT HAVE BROUGHT YOU HERE TODAY:

COMPLAINT 1: _____ DATE SYMPTOMS BEGAN: _____

COMPLAINT 2: _____ DATE SYMPTOMS BEGAN: _____

HAVE YOU BEEN MEDICALLY TREATED IN ANOTHER STATE WITHIN THE LAST YEAR? ☐ NO ☐ YES IF YES, WHERE: _____

DO YOU SUFFER FROM ANY OF THE FOLLOWING? IF YES, PLEASE EXPLAIN.

CHRONIC PAIN? ☐ YES ☐ NO _____
MUSCLE SPASMS? ☐ YES ☐ NO _____
NAUSEA? ☐ YES ☐ NO _____

HAVE YOU EXPERIENCED ANY DIFFICULTIES WITH THE FOLLOWING?

FREQUENT HEADACHES	☐ YES ☐ NO	HIV/ AIDS	☐ YES ☐ NO	DIABETES	☐ YES ☐ NO
MIGRAINES	☐ YES ☐ NO	PACEMAKER	☐ YES ☐ NO	SEIZURES	☐ YES ☐ NO
KIDNEY DISEASE	☐ YES ☐ NO	PNEUMONIA	☐ YES ☐ NO	GLAUCOMA	☐ YES ☐ NO
GOITER	☐ YES ☐ NO	POLIO	☐ YES ☐ NO	CANCER	☐ YES ☐ NO
GOUT	☐ YES ☐ NO	HERNIATED DISC	☐ YES ☐ NO	ANEMIA	☐ YES ☐ NO
PARKINSON'S	☐ YES ☐ NO	SPINE ISSUES	☐ YES ☐ NO	ULCERS	☐ YES ☐ NO
ALS	☐ YES ☐ NO	ARTHRITIS	☐ YES ☐ NO	THYROID ISSUES	☐ YES ☐ NO
HEPATITIS C	☐ YES ☐ NO	STROKE	☐ YES ☐ NO	IBS	☐ YES ☐ NO
LIVER DISEASE	☐ YES ☐ NO	OSTEOPOROSIS	☐ YES ☐ NO	EMPHYSEMA	☐ YES ☐ NO
HIGH BLOOD PRESSURE	☐ YES ☐ NO	CATARACTS	☐ YES ☐ NO	ASTHMA	☐ YES ☐ NO
VALLEY FEVER	☐ YES ☐ NO	MULTIPLE SCLEROSIS	☐ YES ☐ NO	HEART DISEASE	☐ YES ☐ NO
ALZHEIMER'S DISEASE	☐ YES ☐ NO	CROHN'S DISEASE	☐ YES ☐ NO	EPILEPSY	☐ YES ☐ NO
WEIGHT LOSS	☐ YES ☐ NO	ABDOMINAL PAIN	☐ YES ☐ NO	SCHIZOPHRENIA	☐ YES ☐ NO
TROUBLE SLEEPING	☐ YES ☐ NO	TUMORS / GROWTHS	☐ YES ☐ NO	ANXIETY / DEPRESSION	☐ YES ☐ NO

PLEASE LIST ALL SURGERIES AND HOSPITALIZATIONS YOU HAVE EXPERIENCED WITH THE DATE OF OCCURRENCE:

1 _____

2 _____

3 _____

PLEASE LIST WHEN, WHERE, AND WHY YOU HAD ANY OF THE FOLLOWING:

X-RAYS: _____

ULTRASOUNDS: _____

MRI / CAT SCANS: _____

OTHER TESTS: _____

PLEASE INDICATE YOUR USE OF THE FOLLOWING:

STEROIDS ☐ CURRENT ☐ PAST ☐ NA

DRUG ADDICTION ☐ CURRENT ☐ PAST ☐ NA

SMOKING ☐ CURRENT ☐ PAST ☐ NA

ALCOHOL ☐ CURRENT ☐ PAST ☐ NA

RECREATIONAL DRUGS ☐ CURRENT ☐ PAST ☐ NA

HOW MANY PACKS PER DAY? _____ NUMBER OF YEARS? _____

HOW MANY DRINKS PER WEEK? _____

PLEASE LIST ALL MEDICINES AND SUPPLEMENTS THAT YOU ARE CURRENTLY TAKING. PLEASE INCLUDE DOSAGE AMOUNTS IF KNOWN.

1 _____ 4 _____

2 _____ 5 _____

3 _____ 6 _____

IN YOUR OWN WORDS, PLEASE DESCRIBE HOW YOUR CONDITION LIMITS YOU OR DECREASES YOUR QUALITY OF LIFE:

I certify that the information, both written and verbal, that I have provided to Sun Valley Certification Clinic is true and accurate to the best of my knowledge.

_____ _____

Patient Signature **Date**

CONTRADICTIONS AND SIDE EFFECTS ACKNOWLEDGMENT

Cannabis (marijuana) may affect or impair coordination and cognition, as well as the ability to drive, operate heavy machinery and/or engage in potentially hazardous activities.

Vaporizers may substantially reduce many of the potentially harmful smoke toxins that are normally present in marijuana smoke, because although smoking cannabis (marijuana) has not been linked to lung cancer, smoking it can cause respiratory harm such as bronchitis. Many researchers agree that marijuana smoke contains known carcinogens (chemicals that can cause cancer) and that smoking marijuana may increase the risk of respiratory diseases and cancers of the lungs, mouth and tongue. Cannabis smoke contains chemicals known as tars that may be harmful to health.

The side effects, while rare, may occur while taking medical cannabis. These side effects can include, but are not limited to the following:

- Anxiety
- Inability to concentrate
- Difficulty in completing complex tasks
- Sedation
- Alterations in the perception of time and space
- Impairment of motor skills, reaction time and physical coordination
- Low blood pressure
- Dizziness
- Increased appetite
- Increased talkativeness
- Impairment of short-term memory
- Confusion
- Euphoria
- Cough
- Tachycardia (fast heart beat) and heart palpitations
- Paranoia
- Suppression of the body's immune system
- Psychotic symptoms (e.g., delusions, hallucinations)

The potency and effects of cannabis varies. For some patients, chronic marijuana use can lead to laryngitis, bronchitis and general apathy. Some patients can become psychologically dependent on marijuana and could experience withdrawal symptoms when they stop. Symptoms of withdrawal, while generally mild, can include:

- Feelings of depression, sadness or irritability
- Sleep disturbances
- Trouble concentrating
- Loss of appetite

Cannabis is not a food crop and therefore is not regulated by the U.S. Food and Drug Administration and may contain unknown quantities of impurities, active ingredients and/or contaminants. While under the influence of marijuana, the use of alcohol is not recommended. The possibility exists that cannabis may exacerbate schizophrenia in persons predisposed to that disorder.

I HAVE READ AND UNDERSTAND THE STATEMENTS ABOVE AND UNDERSTAND THE POTENTIAL SIDE EFFECTS OF CONSUMING MARIJUANA.

Patient Name (Printed)	Patient Signature	Date

LIABILITY WAIVER AND RELEASE

In consideration of my medical evaluation to be performed by or on behalf of Sun Valley Certification Clinics, I, _____, my heirs, assigns and anyone acting on my behalf, agree to hold Sun Valley Certification Clinics, staff, physicians, and their principals, agents, officers, directors and employees free and harmless from any and all claims, damages and causes of action relating to or arising out of: (1) my use or possession of cannabis (marijuana), or (2) the denial of my application for a medicinal marijuana card for any reason.

I understand and acknowledge that:

1. Sun Valley Certification Clinics is not a Dispensary and cannot provide me with medicinal marijuana or any other medication.
2. A physician's recommendation that I may benefit from the use of medicinal marijuana does not guarantee that the use of medicinal marijuana will be effective at alleviating or helping my pain or any other qualifying condition.
3. If I do not wish to upload my application to the Nevada Department of Health and Behavioral Services today with the help of Sun Valley Certification Clinics, then I understand that I have it will be my sole responsibility and Sun Valley Certification Clinic will not be responsible for any additional fees that may arise from my delay in uploading.
4. I am responsible to know the Nevada State laws regarding legal acquisition and use of medical marijuana -- information available to me on the state website.
5. Neither Sun Valley Certification Clinics nor anyone acting on Sun Valley Certification Clinics's behalf has made any representation to me about the application or enforcement of state or federal law in connection with the possession or use of medicinal marijuana.
6. Neither Sun Valley Certification Clinics's physicians, associates nor staff advises or condones that I discontinue treatment or medication that I currently take.

In addition, I represent that Sun Valley Certification Clinics's Physicians have: (a) explained to me the nature and purpose of medical cannabis (marijuana) treatment, including its benefits and possible side effects; (b) asked me if I have any questions regarding his/her recommendation; and (c) answered those questions, if any, to the best of his/her ability.

ACKNOWLEDGED AND AGREED:

Patient Name (Printed)	Patient Signature	Date

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I received Sun Valley Certification Clinics's Notice of Privacy Practices.

Name of Patient (please print)	**Date of Birth**
Patient Signature	**Date**