Patient Registration

2007 S. Blue Island Avenue
Chicago, IL 60608
312-248-8898

Name:____

Address:____

City/State/ZIP____

Email____

Phone: Cell__________________________ Home_______________________________

Date of Birth: ____

Are you a Veteran or receiving SSI/SDI? (Y/N) _____________________________________

Do you hold a Conceal & Carry or a FOID card? (Y/N) _______________________________

What is/are your qualifying medical condition (s)?

____

Are you currently being treated for your medical condition? (Y/N) _______________________

If yes, what is the name of your doctor? ____

Is your doctor willing to certify you for the program? (Y/N) ___________________________

If not, do you need a doctor referral? (Y/N)_______________________________________

How did you hear about Soul and Wellness?

____

Have you considered having a caregiver apply for a card with you? __________________
(For these purposes the "caregiver" is the person that would be able to go to the dispensary with you or for you.)

Client Signature___________________________ Date_________________________

*Office Admin only

Intake by_______________ Amount paid $__________

Reffered Doctor__________________Dispensary____________

USER:________________

PASS:________________

Last 4 Digits of SSN: _ _ _ _