



420 Plymouth Rd
Plymouth Meeting, PA 19462
(484) 531-4420
www.ilerahhealthcare.com

New Patient Intake Form

DEMOGRAPHIC INFORMATION

Today's Date: _____

Patient Name: _____
(First) (Last)

Date of Birth: ____/____/____
(MM) (DD) (YYYY)

Address: _____
(Street)

Phone Number:
(____) _____ - _____

(City) (State) (Zip)

Permission to leave voicemail?
 YES NO

Email:

PA Department of Health Certified Caregiver Name (if applicable):

Caregiver Phone:
(____) _____ - _____

Caregiver Relationship to Patient: _____

Permission to discuss information with family or other caregivers?
 YES NO

If yes, please provide name and contact information: _____

How did you hear about Ilera Healthcare?

- Friend/Family Web Search Physician Event Social Media
 Leafly / Weedmaps

MARIJUANA CERTIFICATION

Medical Marijuana Card Issue Date: ____/____/____ Expiration Date: ____/____/____
(MM) (DD) (YY) (MM) (DD) (YY)

Name and Specialty of Approved Certifying Physician: _____

Certifying Physician's
Phone: (____) _____

Facility Location: _____

Permission to discuss information with certifying physician?
 YES NO

SOCIAL HISTORY

Have you used marijuana in the past? YES NO
Are you currently using marijuana? YES NO
If "YES", how often? _____ per month _____ per week _____ per day

Do you use any form of nicotine? YES NO
If "YES", what form and how often? Nicotine type: _____ Nicotine Usage: _____ per _____

Do you drink alcohol? YES NO
If "YES", how often? Alcohol Usage: _____ drinks per _____

Do you use any other substance? YES NO
(ex: opioids not prescribed to you, cocaine, LSD, etc.)
Substance type: _____ Substance Usage: _____ per _____
If yes, what form and how often? _____

Other Comments: _____



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FOR OFFICE USE ONLY

Date of Initial Consult: _____

30-day DOH limit: _____ g per 30 days

30-day limit set initially set by Ilera HCP?

YES

NO

Name of Dispensary Employee for Initial Intake:

Signature of Dispensary Employee:

Comments: