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Patient Intake Form

Please complete EXACTLY as it appears on your 329 Hawaii medical card:

DOH Medical Marijuana Program

Registration Number: _____

Issued:_____ Expires: _____

P: _____

DOB:_____

Physician:

/s/ _____

Email: _____Mobile: _____

Registered Caregiver (if applicable): _____ Mobile: _____

A registered caregiver is an individual selected by a patient and registered with the Department of Health to act as their agent in obtaining medication for them at the dispensary.

CHECK HERE IF YOU DO NOT WISH TO RECEIVE MARKETING COMMUNICATIONS ☐

How can we serve you better? (Optional)

1. What is your preferred method of consuming cannabis: circle all that apply

Vaping | Tinctures | Ingestible (capsules or lozenges) | Concentrates (shatter or wax)
Topicals | Edibles | Smoking | Don't Know

2. Please rank the following products 1-6:

1 being the most interested

6 being the least interested

___Concentrates (shatter or wax) ___Tinctures ___Topicals

___Edibles Oil ___Ingestible (capsules or lozenges) ___Vaping Oil

- FLIP OVER -

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Your initials are required next to each acknowledgment:

_____ I attest that I will not engage in the diversion of cannabis. I understand that fraudulent distribution or resale of cannabis is a felony.

_____ I understand that when under the influence of cannabis driving is prohibited and machinery should not be operated.

_____ I understand cannabis, including medical cannabis produced by Noa Botanicals, should be kept away from children.

_____ I acknowledge that Noa Botanicals does not provide medical advice.

_____ I acknowledge that the law prohibits photography and video recording of any kind in the dispensary.

_____ I acknowledge consumption of marijuana or marijuana manufactured products on the premises of the dispensary is prohibited.

_____ I understand there may be health risks associated with using cannabis, including cannabis produced by Noa Botanicals.

_____ I understand I may not distribute marijuana to any other individual.

_____ I agree not to bring any weapons or anything that can be used as a weapon into Noa Botanicals facilities.

_____ I understand that I must have a valid government-issued identification and a valid medical marijuana card during every visit to the Noa Botanicals dispensary.

_____ I acknowledge that I may not purchase more than four ounces of marijuana in a fifteen-day period from any dispensary.

_____ I agree at all times to abide by Hawaii law in regard to my use of medical cannabis and hereby release and waive all claims against Noa Botanicals from any and all liability related to my use of medical cannabis.

_____ I have received the Noa Botanicals patient handbook, a copy of which can be found at noacares.com.

I certify that I the above is true and correct and agree to hold harmless and release Manoa Botanicals LLC dba Noa Botanicals (Noa), and its officers, managers, agents, and employees of any liability related to the use of medical cannabis purchased at the Noa Botanicals dispensary or sold by Noa Botanicals.

(Print) Patient or Caregiver Full Name: _____Date:_____

Signature:_____

This form can be completed prior to your visit. Please bring your completed printed copy along with your unexpired 329 card and valid photo ID for quicker processing.