

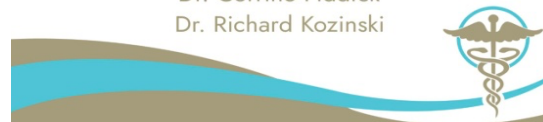
# New Patient Form

Tel: 519-987-1161  
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7775 Wyandotte East, Windsor, Ontario, N8S 1S6  
Email: clinic@kozmed.ca

## Koz Medical

Family Practice

Dr. Corrine Fiddick  
Dr. Richard Kozinski



Last Name		First Name		Middle Name	
Birth date:		Health Card:		Version code:	
Home Telephone:			Cell Phone:		
Address:		City:		Postal Code:	
Email:					

Current Medication:		(Please provide current medication list from your pharmacy)	

Current Pharmacy information:	
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Current family doctor:	
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Reason for leaving current family doctor:	
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Please check YES or NO to the follow questions					
DIABETES	YES <input type="checkbox"/>	NO <input type="checkbox"/>	EPILEPSY (SEIZURES)	YES <input type="checkbox"/>	NO <input type="checkbox"/>
HIGH BLOOD PRESSURE	YES <input type="checkbox"/>	NO <input type="checkbox"/>	CANCER	YES <input type="checkbox"/>	NO <input type="checkbox"/>
HIGH CHOLESTEROL	YES <input type="checkbox"/>	NO <input type="checkbox"/>	BLEEDING DISORDER	YES <input type="checkbox"/>	NO <input type="checkbox"/>
ASTHMA	YES <input type="checkbox"/>	NO <input type="checkbox"/>	ECZEMA / PSORIASIS	YES <input type="checkbox"/>	NO <input type="checkbox"/>
ANEMIA	YES <input type="checkbox"/>	NO <input type="checkbox"/>	GLAUCOMA	YES <input type="checkbox"/>	NO <input type="checkbox"/>
HEART DISEASE	YES <input type="checkbox"/>	NO <input type="checkbox"/>	FIBROMYALGIA	YES <input type="checkbox"/>	NO <input type="checkbox"/>
ARTHRITIS	YES <input type="checkbox"/>	NO <input type="checkbox"/>	PSYCHIATRIC ILLNESS	YES <input type="checkbox"/>	NO <input type="checkbox"/>
STROKE	YES <input type="checkbox"/>	NO <input type="checkbox"/>	ANXIETY / DEPRESSION	YES <input type="checkbox"/>	NO <input type="checkbox"/>
OSTEOPOROSIS	YES <input type="checkbox"/>	NO <input type="checkbox"/>	INSOMNIA	YES <input type="checkbox"/>	NO <input type="checkbox"/>

Other:	
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Tobacco use per week:	Narcotic use in past 2 years:	Allergies:
Alcohol use per weeks:	Exercise per week:	Surgeries:

I agree that all the information in this application to be a patient at Koz Medical is correct and if found at anytime there has been any dishonesty/false information it may lead to termination of my relationships with Koz Medical.

Signature:		Date:	
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