# New Patient Form

Tel: 519-987-1161
Fax: 519-561-6878
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 |
|---|---|---|
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|---|---|---|---|---|---|
| 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) | |
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| Current Pharmacy information: |
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| Current family doctor: | |
| Reason for leaving current family doctor: | |

| Please check YES or NO to the follow questions | | | | | |
|---|---|---|---|---|---|
| DIABETES | YES ☐ | NO ☐ | EPILEPSY (SEIZURES) | YES ☐ | NO ☐ |
| HIGH BLOOD PRESSURE | YES ☐ | NO ☐ | CANCER | YES ☐ | NO ☐ |
| HIGH CHOLESTEROL | YES ☐ | NO ☐ | BLEEDING DISORDER | YES ☐ | NO ☐ |
| ASTHMA | YES ☐ | NO ☐ | ECZEMA / PSORIASIS | YES ☐ | NO ☐ |
| ANEMIA | YES ☐ | NO ☐ | GLAUCOMA | YES ☐ | NO ☐ |
| HEART DISEASE | YES ☐ | NO ☐ | FIBROMYALGIA | YES ☐ | NO ☐ |
| ARTHRITIS | YES ☐ | NO ☐ | PSYCHIATRIC ILLNESS | YES ☐ | NO ☐ |
| STROKE | YES ☐ | NO ☐ | ANXIETY / DEPRESSION | YES ☐ | NO ☐ |
| OSTEOPOROSIS | YES ☐ | NO ☐ | INSOMNIA | YES ☐ | NO ☐ |

| Other: | | |
|---|---|---|
| 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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