

Functional Medicine & Wellness Center

Todd Oczkowski, DC. "Dr. Ozzie"

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Confidential Patient Information Form

Please fill out ALL information: (Please print)

Today's Date _____ Referred by _____

Last Name _____ First Name _____ Middle Initial _____

Home Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Age _____ Date of Birth ____ / ____ / ____ Drivers License No. _____

Sex- Male/Female Marital Status – Single/Married/Divorced/Widowed

Spouse's Name _____

Occupation _____ Employer _____ Work Phone _____

Social Security Number _____ Guardian's SSN (if patient under 18) _____

Person Responsible for account _____ Relationship to Pt. _____

Person to contact in case of emergency _____

Address _____ Phone _____

Date of last physical exam _____ Doctor's name/type _____

Reported findings _____

Has your back or neck been x-rayed within the last 3 yrs? Yes/No Where _____

List all surgeries/serious illness/hospitalizations (Include dates) _____

Have you ever suffered from (circle all that apply)

Dizziness Arthritis Tuberculosis Heart Problems Cancer

Headaches Numbness Breathing Problems Diabetes Venereal Disease

Sinus Problem Neuritis Asthma Rheumatic Fever Backache Nervousness

Digestive Disorders Anemia

What is your major complaint? _____

How long have you had this condition? _____

Have you had this or similar conditions before? _____

What activities aggravate your condition? _____

Improve your condition? _____

Is this condition becoming progressively worse? Yes/No

Status of your condition? Constant/Comes and goes

This condition interferes with (circle all that apply) Work/Sleep/Daily/Routine/Other

List previous diagnosis/treatments you have received for this condition: _____

Additional Complaints? _____

What current medications/drugs are you taking? (list reason for taking) _____

Patient Information:

Do you have insurance? Yes/No Insurance Company's name: _____

Is this a work-related injury ? Yes/No Motor vehicle accident? Yes/No

If yes is this your first doctors visit ? Yes/No

I hereby give my consent to the Functional Medicine & Wellness Center (Todd Oczkowski, D.C.) to provide services to myself/or family member. I understand that there is a fee for services, and that fees are payable at time services are rendered. I hereby agree to such fees, and understand that I am liable for any and all legal fees if collection services become necessary.

Responsible Party/Patient _____ **Date** _____

For Insurance/Worker's Compensation filing: I authorize the release of any medical or other information necessary to process claims. I also request payment of medical benefits to Todd Oczkowski, D.C. for services rendered.

Signature of Insured _____ **Date** _____