KENNETH ODINET DDS MD

PATIENT PROFILE

Date: _____

How did you hear about Dr. Odinet's Services?

☐ Internet ☐ Billboard ☐ Radio ☐ Dr. Name: _____ ☐ Friend Name: _____

Patient's Information:

Patient's Last Name: _____ First: _____ Middle Initial: _____

Mailing Address: _____ City, State, Zip Code: _____

Sex: ☐ Male ☐ Female Social Security #: _____ Date of Birth: _____

Home Phone #: _____ Work #: _____ Employer: _____

Cell Phone #: _____ Email Address: _____

Preferred Form of Communication: ☐ HomePh # ☐ CellPh# ☐ Email:

Marital Status: ☐ Single ☐ Other ☐ Married to: _____

Emergency Contact & Relation: _____ Phone: _____

Insurance Information: Please fill this sections out using your insurance card (s)

Please select one of the following: ☐ Health Insurance ☐ Worker's Compensation ☐ Attorney ☐ Self-Pay

If this is accident/injury related: Accident/Injury/Onset Date: ____/____/_____

Primary Insurance Company: _____ Patient's Phone #: _____

Subscriber's Name: _____ Subscriber's Social Security #: _____

Date of Birth: _____ Policy #: _____ Group #: _____

Patient's Relationship to subscriber: ☐ Self ☐ Spouse ☐ Child Other: _____

Secondary Insurance Company: _____ Patient' Phone number: _____

Subscriber's Name: _____ Subscriber's Social Security #: _____

Date of Birth: _____ Policy #: _____ Group #: _____

Patient's Relationship to subscriber: ☐ Self ☐ Spouse ☐ Child Other: _____

The above information is true to the best of my knowledge. I authorize my Insurance benefits be paid directly to the office. I understand that I am financially responsible for any unpaid balance, I also authorize the Office or Insurance Company to release any information required to process my claims. I hereby acknowledge that I have received the Kenneth L. Odinet, D.D.S., M.D., APMC Notice of Privacy Practices and Patient Rights and Responsibilities.

Patient/Guardian Signature: _____ Date/Time: _____

KENNETH L. ODINET, D.D.S., M.D.

HEALTH HISTORY

Health problems that you may have or medication you are on may have an important interrelationship with the overall care that you receive. Please answer the following questions to the best of your knowledge. The answers are for our records only and will be considered confidential.

Patient Name:_____ **Date:**_____

Referring Doctor or Source:_____ Reason for Visit:_____

Primary Care _____ Cardiologist _____ OBgyn _____

MEDICAL HISTORY: Please check all the medical conditions that you have or have ever had:

_____High Blood Pressure	_____Diabetes
_____Lung Disease (Emphysema, TB, Asthma)	_____Heart Attack
_____Liver Disease (Jaundice, Hepatitis)	_____Stroke
_____Kidney Disease (Stones)	_____Digestive Problems (Acid Reflux/Ulcer)
_____Chemotherapy	_____Radiation
_____Bleeding Complications/Tendencies	_____Keloids (Scars)
_____Breast Disease	_____Sexually Transmitted Disease
_____Anesthesia Problems (High fever, Nausea)	_____Contact Lenses/ Glasses

_____Other:_____

List all operations and the year performed:_____

Operation:_____Year_____

Operation:_____Year_____

Family History: (Please specify: parent, sibling, grandparent, maternal/paternal) Put stars: *

High Blood Pressure: _____Who? _____

Cancer: Type: _____Who? _____

_____

Social History:

Do you smoke? _____ Have you ever smoked? _____ Amount:_____

Do you drink alcohol? _____ Frequency? _____

Do you use social drugs? _____ What kind? _____ Frequency? _____

Is there a chance that you may be pregnant? _____

Have you ever had steroid therapy? _____ What type? _____

Weight:_____ Height:_____ Drug allergies:_____

_____Reaction:_____

List all Medications you are taking, frequency, and amount:_____

Include all over the counter medication:

_____

_____

_____

_____

Patient Signature:_____ Date:_____

M.D. Signature:_____ Date:_____