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: _____