Date:_______________

**Patient's Information**

Last Name:________________________________ First Name:_________________________________ M.I._______

Mailing Address:__________________________________ City, State, Zip Code:______________________________

Date of Birth:______________ **Social Security #:**___________________________ Sex: ☐Male ☐Female

Cell Phone #:__________________________ **Email Address:**______________________________________

Home Phone #:____________________ Work Phone #:___________________ Employer:______________________

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

**Emergency Contact**:_________________________________________ Phone #:_____________________

**Insurance Information:**

☐ Health Insurance ☐Worker's Compensation ☐Attorney ☐ Self-Pay

**If this is accident/injury related:** Onset Date:________________

**Primary Insurance Company:**_________________________________ Subscriber's Name:______________________

Subscriber's Social Security:________________________ Date of Birth:__________________

Policy #:_______________________________ Group #:_________________________________

Patient's relation to Subscriber:_____________________________

**Secondary Insurance Company:**_______________________________ Subscriber's Name:______________________

Subscriber's Social Security:________________________ Date of Birth:__________________

Policy #:_______________________________ Group #:_________________________________

Patient's relation to Subscriber:_____________________________

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 of 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:________________

## HEALTH HISTORY

**Patient Name:**_______________________________________________ Date:____________________

Referring Doctor or Source:______________________________ Reason for Visit:________________________________

Primary Care:______________________ Cardiologist: ______________________ OBGYN: ______________________

Height:_____________ Weight:____________

**Drug Allergies & Reactions:** ____________________________________________________________________

______________________________________________________________________________________________

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

_____ High Blood Pressure
_____ Lung Disease (Emphysema, TB, Asthma)
_____ Liver Disease (Jaundice, Hepatitis)
_____ Kidney Disease (Stones)
_____ Chemotherapy
_____ Bleeding Complications/Tendencies
_____ Breast Disease
_____ Anesthesia Problems (High fever, Nausea)
_____ Diabetes
_____ Heart Attack
_____ Stroke
_____ Digestive problems (Acid Reflux/Ulcer)
_____ Radiation
_____ Keloids (Scars)
_____ Sexually Transmitted Disease
_____ Contact Lenses/ Glasses
_____ Other: ____________________________________________________________________________________

*__Have you or a family member had a reaction that was a medical emergency following a surgery from anesthesia?__ ☐ **YES** ☐ **NO**

**List all operations and the year performed:**

Operation: _______________________________________________________________ Year: _______________

Operation: _______________________________________________________________ Year: _______________

**FAMILY HISTORY:** (Please specify: parent, sibling, grandparent, maternal/paternal)

High Blood Pressure: ____________________________________________________

Breast Cancer: _________________________________________________________

Cancer (Other): ________________________________________________________

**SOCIAL HISTORY:**

Do you smoke/ Vape/ Chew Tobacco? _______ Have you ever smoked? _______ Amount: ______________________

Do you drink alcohol? _______ Frequency:___________________________

Do you use social drugs? _______ What kind? ___________________ Frequency:_____________________________

Is there any chance you may be pregnant? __________

Have you ever had steroid therapy? __________ What type? ___________________________________

**List all medications you are currently taking, dose, and frequency:** ______________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

**Patient Signature:** _________________________________________________________ Date:________________

**M.D. Signature:**___________________________________________________________ Date:________________

# Dr. Odinet Cancellation Policy

Effective Immediately

Due to the demand for appointments, we are enforcing our 48-hour cancellation policy.

All cancellations with less than a 48-hour notice and missed appointments will be charged a fee of $50.00 that day. If you cannot make your appointment, we kindly ask that you give us a call 48 hours prior to cancel and/ or reschedule.

Our phone number is (337) 234-8648

Thank you for understanding.

Please sign below indicating you are aware and understand our policy.

Signature:_________________________________ Date:_____________

Patient Name:_________________________

Date of Birth: ________________________

Phone Number: _______________________

Please let us know which of our services you would like to learn more about.

- ☐ Facial Rejuvenation/Tightening
- ☐ Make up Application
- ☐ Photo/Sun Damage
- ☐ Microneedling
- ☐ Skincare/Product consult
- ☐ Laser Treatments
- ☐ Laser Hair Removal
- ☐ Botox and Filler Injections

Email address: ___________________________________

☐ YES, I'd like to learn more about what Dr. Kenneth Odinet's office has to offer. Please sign me up for email specials!

* Let our team of professionals guide you through a consultation to determine a detailed treatment guide.

For the provider

Date called: ___________ Time called:___________

- ☐ Patient scheduled.
- ☐ Patient will call to schedule.
- ☐ Patient did not schedule.