PRESIDENTIAL HEALTHCARE CENTER

Patient Information Record

I. DEMOGRAPHIC INFORMATION □ NO CHANGE FROM RECORD DATE _____

NAME			DATE OF BIRTH	GENDER M F
HOME ADDRESS			SSN	
			HOME PHONE	
CITY	STATE	ZIP	WORK PHONE	
ALTERNATE ADDRESS			CELL PHONE	
EMPLOYER	ASSISTANT		FAX	
EMAIL ADDRESS	EMAIL ADDRESS 2		OTHER CONTACT NUMBER	
PHARMACY			PHARMACY PHONE	

Marital Status: □ Single □ Married □ Divorced □ Widowed

II. BILLING INFORMATION

NAME OF PERSON RESPONSIBLE FOR CHARGES □ CHECK IF SAME AS ABOVE		RELATIONSHIP	DATE OF BIRTH
ADDRESS	CITY, STATE, ZIP		TELEPHONE
EMPLOYER/EMPLOYER ADDRESS			EMPLOYER TELEPHONE
PRIMARY INSURANCE CARRIER	ID #		GROUP/PLAN
PRIMARY INSURANCE POLICY HOLDER (IF NOT PATIENT)	PRIMARY INS. POLICY HOLDER'S SSN (IF NOT PT)		PRIMARY INS HOLDER TEL.
SECONDARY INSURANCE CARRIER	ID #		GROUP/PLAN
SECONDARY POLICY HOLDER (IF NOT PATIENT)	SECONDARY POLICY HOLDER'S SSN (IF NOT PT)		

*****PHOTOCOPY INSURANCE CARD, CREDIT CARD, AND PHOTO ID FRONT/BACK *****

I hereby authorize the above physician(s) to release any information regarding services rendered and allow a photocopy of my signature to be used to file insurance. I agree to pay in full at time of service and authorize submission of claims to my health insurance carrier. I understand that I will remain liable for all physician's charges, and in the event of past due accounts, I understand that collection costs, court costs, and reasonable attorney's fees will apply to all past due accounts. I hereby authorize and direct payment check (s) for benefits due for the services rendered by the above-named physician (s) to be made directly to the physician unless otherwise specified. I also acknowledge that I understand that for laboratory studies, and consultation fees for assessment of acute medical problems, the charges will be billed to my insurance and it is possible that preauthorizations, co-payments and additional charges may apply, and I will be responsible for those charges. In the event that full payment is not made within 60 days of service, I authorize a charge to my credit card on file for the balance due.

Date _____ Patient's Signature _____