American Health Network
Part of Optum®

Fredericktown
American Health Network of Ohio, LLC
122 Columbus Rd
Fredericktown, OH 43019-1266
USA
(740) 694-1261

PATIENT INFORMATION

NAME (Last, First, Middle)	MRN	SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS	CITY, STATE, ZIP	REFERRING PHYSICIAN	SECONDARY BILLING ADDRESS (if applicable)		
HOME PHONE	DAY PHONE	E-MAIL ADDRESS	PRIMARY CARE PROVIDER	CITY, STATE, ZIP	
MARITAL STATUS	STUDENT STATUS ☐ Full Time ☐ Part Time	SMOKER (Y/N?)	VETERAN (Y/N?)	EMERGENCY CONTACT NAME	CONTACT PHONE	HOME PHONE

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if applicable)
ADDRESS	ADDRESS
CITY, STATE, ZIP	CITY, STATE, ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if different than above)

NAME (Last, First, Middle)	SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS	CITY, STATE, ZIP	REFERRING PHYSICIAN	SECONDARY BILLING ADDRESS (if applicable)	
HOME PHONE	DAY PHONE	E-MAIL ADDRESS	CITY, STATE, ZIP	
MARITAL STATUS	STUDENT STATUS ☐ Full Time ☐ Part Time	SMOKER (Y/N?)	VETERAN (Y/N?)	PRIMARY CARE PROVIDER	HOME PHONE
RELATIONSHIP TO PATIENT				

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY #	
NAME OF INSURED		GROUP #	
ADDRESS OF INSURANCE COMPANY		COPAY AMT $	
CITY, STATE, ZIP	PHONE	DEDUCTIBLE $	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if applicable)

NAME OF INSURANCE COMPANY		POLICY #	
NAME OF INSURED		GROUP #	
ADDRESS OF INSURANCE COMPANY		COPAY AMT $	
CITY, STATE, ZIP	PHONE	DEDUCTIBLE $	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

I understand that AHN will use my address/phone # listed above to leave messages regarding: the availability of test results, appointment reminders, etc., unless I request that the following alternative contact information be used: (e.g. work #, cell # of family member/friend)

I request/authorize AHN to furnish the medical care necessary for my condition and understand that no guarantees as to the results have been made to me. I acknowledge I was offered a copy of the AHN Privacy Notice and Patient Financial Policies (including the Medicare agreement if applicable). I agree to abide by the terms of the Financial Policies, Terms and Conditions.

SIGNATURE OF PATIENT/GUARDIAN ______________________ DATE ____________