American Health Network
Part of Optum®

Patient information

Chart #

Patient last name	First name, MI	Date of birth	SSN

Home address (include Apt #)
Street City, State, ZIP

Sex	Marital status	Phone
M F	S M W D Sep	Home ( ) Work ( ) Cell ( )

Employment status	Employer name and address (if student, name of school)
☐ Full time ☐ Part-ime ☐ FT student ☐ PT student ☐ Retired	

Primary care physician (PCP) PCP phone City and state

Legal guardian (if patient is under age 18) Relationship	Referring physician (if different than PCP) City, State

Emergency contact (outside of home)
Name Relationship Phone

Alternate contact (name and phone or email; initials of parent/legal guardian if patient is a minor)

PRIMARY INSURANCE INFORMATION

Primary insurance company	Member/policy #	Group #	Effective date

Policy holder name (if other than self)	Policy holder DOB (If other than self)	Policy holder SSN (if other than self)

Relationship to patient (if other than self)	Policy holder employer (if other than self)	Policy holder employer phone #

Claims address (if insurance card was not provided)

SECONDARY INSURANCE INFORMATION

Secondary insurance company	Member/policy #	Group #	Effective date

Policy holder name (if other than self)	Policy holder DOB (If other than self)	Policy holder SSN (if other than self)

Relationship to patient (if other than self)	Policy holder employer (if other than self)	Policy holder employer phone

Claims address (if insurance card was not provided)

I UNDERSTAND THAT AMERICAN HEALTH NETWORK WILL USE MY HOME ADDRESS/PHONE # TO LEAVE MESSAGES REGARDING TEST RESULTS, APPOINTMENTS, ETC., UNLESS I REQUEST THAT THE FOLLOWING ALTERNATIVE CONTACT BE USED (FOR EXAMPLE, CELL # OF FAMILY MEMBER/FAMILY):

I REQUEST/AUTHORIZE AMERICAN HEALTH NETWORK TO FURNISH THE MEDICAL CARE THAT IS NECESSARY FOR MY CONDITION, BUT I ACKNOWLEDGE THAT NO GUARANTEES AS TO THE RESULTS HAVE BEEN MADE TO ME. I WAS PROVIDED A COPY OF THE PRIVACY NOTICE AND PATIENT FINANCIAL POLICIES (INCLUDING THE MEDICARE AGREEMENT IF APPLICABLE). I HAVE READ, UNDERSTOOD AND HAD THE OPPORTUNITY TO ASK QUESTIONS AND I AGREE TO ABIDE BY THESE TERMS.

Signature of patient/guardian _____ Printed name _____ Date _____

AHN notes

08/20/2020 (IN & OH)

TELEPHONE & TEXT MESSAGING COMMUNICATION CONSENT

Patient First Name: _____ MI_____ Patient Last Name: _____

DOB: _____ MRN: _____

I hereby consent to, and authorize American Health Network, to contact me via email and/or postal mail, land-based or cellular telephone personal, artificial or pre-recorded voice calls or short message service (SMS or Text) at the telephone numbers listed by me below for these purposes:

- ☐ Medical Alerts
- ☐ Appointment Information
- ☐ Patient Surveys
- ☐ Office Closures due to unforeseen circumstances (i.e. weather)
- ☐ Health Tips
- ☐ Business matters including billing, collections and insurance
- ☐ News and Promotions
- ☐ Availability of seasonal vaccines or services
- ☐ All of the above

This consent may be withdrawn by the patient at any time, by any reasonable means, including but not limited to the following:

1. Text message in response to text message received from American Health Network
2. Via telephone by calling American Health Network at Toll-free: 1-888-255-2246 or
3. Via "Contact Us " at https://www.ahni.com

I certify that I am at least eighteen (18) years of age and may be contacted via any method set forth above at any of the following telephone numbers which have been assigned to me by the utility carrier providing communication services:

Send text messages to this Cell Phone Number: _____

Land-line Telephone Number: _____

Patient's Signature_____ Date: _____

Patient Representative: _____ Date: _____

Parent/Guardian's Signature (if patient is under 18) _____ Date: _____