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	EMAIL ADDRESS	PRIMARY CARE PROVIDER	CITY, STATE ZIP

RACE (Circle One) (CDC Categories)

American Indian/ Alaska Native Asian Black/African American Decline to Specify Hispanic/Latino Other White Caucasian

ETHNICITY (Circle One): (CDC Categories)

Decline to specify Hispanic Hispanic or Latino Non-Hispanic Not Hispanic or Latino

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	SECONDARY BILLING ADDRESS (If Applicable)

HOME PHONE	DAY PHONE	EMAIL 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		DEDUCTIBLE	$
RELATIONSHIP TO PATIENT	PHONE	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		DEDICTIBLE	$
RELATIONSHIP TO PATIENT	PHONE	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** _____