Welcome to American Health Network pediatric medicine located in Grove City
Please fill out this form completely

Patient's Name: _____ **Date Of Birth _____Age _____ Sex _____**

Father's Name: _____ **Mother's Name _____**

Date of Birth: _____ **Date of Birth: _____**

Marital Status: _____ **Marital Status: _____**

Address: _____ **Address: _____**

City: _____ **City: _____**

State: _____ **State: _____**

Home Phone: _____ Cell: _____ **Home Phone: _____ Cell: _____**

Social Security #: _____ **Social Security #: _____**

Driver's License #: _____ **Driver's License #: _____**

Employer: _____ **Employer: _____**

Employer phone #: _____ **Employer phone #: _____**

Insurance Co: _____ **Insurance Co: _____**

Email: _____ **Email: _____**

May we contact you by email? Yes No **May we contact you by email? Yes No**

Who is financially responsible, by law, for your child?

Name:_____ **Phone:_____**

In case of emergency, please list the name of someone not living in your household.

Name: _____ Relation: _____

Home #: _____ Work #: _____

Do you have other children who come to this practice? Is so, please list.

Sibling Name _____ Date of Birth _____ Sex _____ Age _____

Sibling Name _____ Date of Birth _____ Sex _____ Age _____

Sibling Name _____ Date of Birth _____ Sex _____ Age _____

Sibling Name _____ Date of Birth _____ Sex _____ Age _____

Payment is required at the time the service is rendered. Please provide us with you Insurance card so that we may make a copy for the chart.

Assignment and Release

I hereby authorize that my insurance benefits be paid directly to the physician and I authorize the physician to release any information required to process my claims. I acknowledge that I am financially responsible for all non-covered services. I understand that whoever brings my child to their visit must be prepared to make applicable payment or co-payment at the time of service.

Signature: _____ **Date: _____**

****HIPAA Agreement on back** over please →**