Ashok P.C.
Ashok Rambhai Patel, MD

3116 N. Elizabeth Street
Pueblo, CO 81008
Phone: 719-542-7222 Fax: 719-542-5034

3220 N. Academy, Suite 1
Colorado Springs, CO 80917
Phone: 719-637-1222 Fax: 719-637-8385

Patient	(Please Circle) Male Female		
Full Printed Name	DOB - -	Age	SSN - -
Mailing Address	City	State/Zip	
Home Phone	Work Phone	Cell Phone	
Email Address			
Referring Physician's Full Name / Phone	**Primary Care Physician's Full Name / Phone**		
In case of emergency, who should be notified? (Name/Phone)			
How did you learn about our practice?			

If patient is a minor Legal Parent / Guardian - Guarantor	☐ Father ☐ Mother ☐ Other _____		
Full Printed Name	DOB - -	Age	SSN - -
Mailing Address	City State/Zip	Main Phone	
Employer / Address		Work Phone	

Other Parent / Guardian	☐ Father ☐ Mother ☐ Other _____		
Full Name	DOB - -	Age	SSN - -
Mailing Address	City State/Zip	Home Phone Cell Phone	
Employer / Address		Work Phone	

Medical Insurance Information

PRIMARY Insurance	Group No.	Member No.
Type of Policy: (Please Circle) Group Private HMO Health Plan	Deductible: Co-Pay: **We request that deductibles and co-pays be paid at time of service**	
***Are any of the following required?** ☐ **Referral from Primary Care Physician** ☐ **Prior Authorization**		
Name / Address of Policy Holder	City State/Zip	Telephone
DOB - -	Relationship to Patient:	

SECONDARY Insurance	Group No.	Member No.
Type of Policy: (Please Circle) Group Private HMO Health Plan	Deductible: Co-Pay: **We request that deductibles and co-pays be paid at time of service**	
***Are any of the following required?** ☐ **Referral from Primary Care Physician** ☐ **Prior Authorization**		
Name / Address of Policy Holder	City State/Zip	Telephone
DOB - -	Relationship to Patient:	

----------**Patient or Authorized Person's Signature**----------

I authorize providers at Ashok P.C. to provide care as they deem appropriate. I also authorize AAASC to release to my insurance carrier any medical information necessary to process all claims. I understand I am financially responsible for all charges including interest and billing charges. I authorize payment of medical benefits directly to providers at Ashok P.C. I reviewed "Privacy of Your Health information form" and authorize Ashok P.C. to leave messages on my home telephone with my family members and/or relatives.

Signature: _____ **Date:** _____