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: | SSN:

---**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:** ______________

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