

Ashok P.C.
Ashok Rambhai Patel, MD

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Pueblo, CO 81008
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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	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Other _____
Full Printed Name	DOB	Age	SSN
Mailing Address		City	State/Zip
Employer / Address		Main Phone	
		Work Phone	
Other Parent / Guardian	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Other _____
Full Name	DOB	Age	SSN
Mailing Address		City	State/Zip
Employer / Address		Home Phone	
		Cell Phone	
		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? <input type="checkbox"/> Referral from Primary Care Physician <input type="checkbox"/> 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? <input type="checkbox"/> Referral from Primary Care Physician <input type="checkbox"/> 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: _____