## Ashok P.C.

Ashok Rambhai Patel, M.D.

## **Board-Certified Allergist**

Trained at National Jewish Health, Denver

(Please Circle)	Male	Femal	e				
		DOB		Age		SSN	
Mailing Address City State/Zip							
ne 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					□ Ot	her	
Ull Printed Name DOB					Age	SSN	
ess City State/Zip				Main Phone			
Employer / Address					Work Phone		
Other Parent / Guardian							
		DOB	3 Age			SSN	
City						e	
Employer / Address Wor					(Phone	9	
Medical Insurance Information							
PRIMARY Insurance Group No. Member					No.		
o Private HMO	Healt	h Plan	Deductible:			Co-Pay:	
(Please Check)       Group       Private       HMO       Health Plan       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         □         □         □							
e / Address of Policy Holder City State/Zip				Zip	Telephone		
DOB Relationship to Patient:							
	Grou	ip No.			IV	lember No.	
(Please Check) Group Private HMO Health Plan 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							
Iame / Address of Policy Holder         City			State/Zip Telephone				
DOB Relationship to Patient: SSN:							
	Work Phone Work Phone Work Phone Work Phone Work Phone Work Phone N Definition Work Phone N Definition Work Phone City Definition De	City Work Phone  Phone be notified? (Name/Phone) be notified? (Name/Ph	DOB City Work Phone Primary d be notified? (Name/Phone) tice? Pent / Guardian - Guarantor City State/Z City State/Z City State/Z DOB City State/Z City State/Z City State/Z City State/Z City State/Z City State/Z City State/Z City State/Z City State/Z State/	DOB   City   Work Phone   Primary Care Physician   d be notified? (Name/Phone)   tice?   ent / Guardian - Guarantor   Pather   DOB   City   State/Zip     City     State/Zip     City     State/Zip     City     State/Zip     City     State/Zip     City     State/Zip     State/Zip	DOB       Age         City       State/Zi         Work Phone       Cell I         e / Phone       Primary Care Physician'         at be notified? (Name/Phone)       Teather         tice?       DOB         ent / Guardian - Guarantor       Father         DOB       DOB         City       State/Zip         City       State/Zip         City       State/Zip         Hom       DOB         City       State/Zip         Hom       City         City       State/Zip         Hom       City         Group No.       Member         City       State/Zip         Image: City       State/Zip         City       State/Zip         Image: City       State/Zip         Image: City       State/Zip         Image: City       State/Zip         Image: City       State/Zip	DOB       Age         City       State/Zip         Work Phone       Cell Phone         e / Phone       Primary Care Physician's Full I         d be notified? (Name/Phone)       d be notified? (Name/Phone)         tice?       DOB       Age         ent / Guardian - Guarantor       IFather       Mother       Other         DOB       Age       Qae       Qae         City       State/Zip       Main       Work         Image: Dob       Age       Qae       Qae         City       State/Zip       Home Phone       Cell Phone         Image: Dob       Age       Qae       Qae         City       State/Zip       Home Phone       Qae         City       State/Zip       Home Phone       Qae         Image: Qae       Group No.       Member No.       Qae         Image: Qae       Referral from Primary Care Physician       Prio         Image: Qae       City       State/Zip       Tele         Mip to Patient:       Group No.       Me       Ne         Image: Qae       Private       HMO       Health Plan       Deductible:         Ver request that deductibles a       Qae       Qae       Qae	

-----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:

Typing your name is equivalent to your handwritten signature

By typing my signature and sending it via the Internet, I acknowledge that I have read and understand all information provided in this form; that I intend Ashok PC to rely upon it; that I intend to be bound thereby; and that I understand and agree that my electronic signature is the equivalent of a manual written signature.