Ashok P.C.
Ashok Rambhai Patel, M.D.
Board-Certified Allergist
Trained at National Jewish Health, Denver

540 E 540 E Abriendo Ave. Suite D,
Pueblo, CO 81004
Phone: 719-542-7222 Fax:719-696-6010

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 Check) 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 Check) 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:** _______________________________

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.