Allergy and Asthma Care P.C
Dr. M. N. Savliwala M.D.
43700 Woodward Ave # 205 Bloomfield Hills, Michigan 48302 Tel: 248-)335-0200 Fax: 248-335-3760

Patient's Name _____ Date _____

Date of Birth _____ Age _____ Marital Status _____ Sex M ☐ F ☐

Race: _____ Ethnicity: _____

Address _____ City _____

State _____ Zip _____ Phone # _____ Cell # _____ Work# _____

Email Address _____

Social Security # _____ Occupation _____

Primary Care Physician _____ Phone # _____

If Married, Spouse's Name _____

Email Address _____ Cell # _____ Work Phone # _____

Emergency Contact (other than parent or spouse) _____

Relationship _____ Phone # _____

For Patients under 21,

Mother's Name _____

Address, if Different _____

Cell # _____ Home # _____ Work Phone # _____

Email Address _____

Father's Name _____

Address, if Different _____

Cell # _____ Home # _____ Work Phone # _____

Email Address _____

Who is Financially Responsible for this Bill? _____

Their Social Security # _____ Driver's License # _____

Address, if Different _____

Primary Insurance _____

Subscriber's Name _____ Birth date _____ Social Security _____

Contract # _____ Group # _____ Relationship to Patient _____

Secondary Insurance _____

Subscriber's Name _____ Birth date _____ Social Security _____

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Medical History Information

What are your symptoms? _____

How long have you had these symptoms? _____

What medicines have you been taking to relieve symptoms? _____

What medicines do you take on a regular basis? _____

Known allergies to medications: _____

Known allergies to foods: _____

Known allergies to insect bites/stings: _____

Does anyone smoke at home? _____ Any pets in the home? _____

Any fireplaces or woodburning stoves in the home? _____

List any other medical problems besides allergies: _____

Family history of allergies, asthma, or hives: _____

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Consent Information

As a service to our patients, we call your insurance to get a description of benefits. This office is not responsible for incorrect benefits information given to us by your insurance carrier, or changes in coverage after verification date. A description of benefits is not a guarantee of coverage and cannot be relied on as such. I understand that, regardless of my insurance status, I am ultimately responsible for the balance on my account for professional services rendered. I give my consent to scan my driver's license in my health chart for collection of any monies owed by me. I will notify you of any changes in my insurance or health status, or the information on this form. I authorize my insurance and/or Medicare benefits to be paid directly to M. N. Savliwala/Allergy and Asthma Care, P.C. for their professional services. I also authorize M. N. Savliwala, M.D. / Allergy and Asthma Care, P.C. to release any information about me to my insurance company (or Medicare) in order to determine these benefits or benefits for related services.

I acknowledge I have received the Notice of Privacy Practices.

Also, to give information to spouses, significant others, and to parents/children, or guardians, we must have written permission. Please state who it is OK to give your personal health information to.

It is OK to give information to: _____ Relationship _____

_____ Relationship _____

_____ Relationship _____

We will leave health information regarding you on your answering machine at the number you provided us with, unless you instruct us otherwise.

Print Name _____

Patient or Personal Representative Signature _____

Relationship to Patient _____ Date _____