HEALTH INVENTORY

PATIENT ________________________________

PROBLEM THAT BROUGHT YOU HERE:

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MEDICATION ALLERGIES:

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CURRENT MEDICATIONS:

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REASONS THAT YOU ARE TAKING THESE MEDICATIONS:

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SURGICAL HISTORY:

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SMOKING HISTORY:

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CONSENT

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim to the above billing agent (or in the case of Medicare Part B, to the Social Security Administration). This authorization may be revoked by either me or my insurance carrier at any time in writing.

I consent to the treatment necessary for the care of the above named patient. I authorize the release of all medical records to my referring physician and to my insurance company if applicable. I allow fax transmission of my medical records if necessary.

I understand that payment of charges incurred is due at the time of services unless other financial arrangements have been made prior to treatment. Should my account become delinquent, I will be responsible for the accrued charges as well as any collection agency fees which may be based on a percentage at a maximum of 30% of the debt and all costs and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

I do hereby authorize David J. Hoyt, MD, LLC to apply for benefits on my behalf for covered services rendered. I request payment from my insurance provider be made directly to David J. Hoyt, MD, LLC.

SIGNATURE:________________________________

DATE: ________________________________