DAVID J. HOYT, M.D., L.L.C.
Otolaryngology & Audiology

HEALTH INVENTORY

PATIENT: _____

DOB: _____

REASON FOR VISIT:

_____

_____

MEDICATION ALLERGIES:

_____

CURRENT MEDICATIONS:

_____

_____

_____

_____

_____

MEDICAL HISTORY (REASONS YOU ARE TAKING THESE MEDICATIONS):

_____

_____

_____

_____

FOLLOWED BY ANY OTHER SPECIALIST, CARDIOLOGY, PULMONOLOGY, ETC:

_____

SURGICAL HISTORY:

_____

_____

_____

_____

SMOKER: ___ **NEVER** ___ **FORMER**

If current, how many packs a day? _____

CONSENT

I certify that the information I have reported with regard to my insurance coverage and medical history is correct and true. I 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 understand that payment of charges incurred is due at the time of services rendered 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 attorney's fees we incur in such collection efforts.

I do hereby authorize David J. Hoyt, M.D. 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, M.D. LLC.

*Responsible Party or Patient Signature:

_____

*Date: _____

RECORDS RELEASE & CONSENT TO TREAT:

I consent to the treatment necessary for the care of the above-named patient. I authorize the release of all medical records to and from my referring physician, my insurance company, or any other applicable medical provider, past or present, as is needed and necessary to my care and treatment. I allow fax or electronic transmission of my medical records if necessary.

*Responsible Party or Patient Signature:

_____

*Date: _____