Thermography Patient Information Sheet

Name_____ D.O.B._____

Address _____

Phone (H) _____ (C) _____

Email address _____

Occupation _____

Previous Illnesses:

Previous Surgery:

Current Health Problems:

Medication _____

Other Treatment _____

Current Doctor _____

Were you referred to us? Yes _____No _____

Name of person or group who referred you?_____

May we thank them? Yes _____No _____

How do you want to receive your report? (Circle one) Email or Print

PATIENT DISCLOSURE

This information is confidential. All information is correct to my knowledge. I understand that the Report generated from my images is intended for use by trained health care providers to assist in evaluation, diagnosis and treatment. I further understand that the Report is not intended to be used by individuals for self-evaluation or self-diagnosis. I understand that the Report will not tell me whether I have any illness, disease, or other condition but will be an analysis of the Images with respect only to the thermographic findings discussed in the Report. By signing below, I certify that I have read and understand the statements above and consent to the examination.

Signed _____ *Today's Date* _____