Thermography Patient Information

Name: _____ **Birthdate:** _____

Address: _____

Phone: (H) _____ **(C)** _____

Email: _____

General History: Past traumas, diseases, or injuries?

Family Hx: Please include the relationship between you and the family member.

Dental History:

Previous Surgery:

Current Health Problems:

Medications _____

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 ____

Please create a 4 digit pin for opening your password protected emailed report ____ ____ ____ ____

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.

Signature _____ ***Today's Date*** _____