Date: _____
Ref #: _____
ID #:_____
Scan done:

PATIENT INFORMATION SHEET

This information is confidential.

NAME: _____ DOB: _____

ADDRESS: _____

PHONE: _____ CELL: _____

EMAIL: _____

OCCUPATION: _____

Previous Illness: _____

Previous Surgery: _____

Current Health Problems/diagnosed: _____

Medication(s): _____

Other Treatment: _____

Dental History:_____# of fillings _____# of crowns _____# of pulled teeth other:_____

Skin lesions/physical abnormalities:_____

Family History: Mother:_____Father:_____

Brother:_____Sister:_____

Maternal Grandparents:_____Paternal:_____

Medical Physician: _____Phone: _____

Do you want a copy of the Digital Thermal Imaging report printed ($5.00 fee applies): Yes:_____ No: _____

Patient Disclosure: I understand than the Report generated from my images is intended for use by trained healthcare providers to assist in evaluation, diagnosis and treatment. I further understand that the Report is not intended for self-evaluation or self-diagnosis. I understand that the Report will **not** tell me if I have any illness, disease or other condition, but will be an analysis of the images with respect to the thermographic findings discussed in the Report. I certify by my signature, that I fully understand the above statements and all data documented above is correct in regards to my health history.

Signature: _____ Date: _____

Frisina Possibilities
Digital Infrared Thermal Imaging
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