COMPLETE THERMAL IMAGING LLC

NEW PATIENT FORM

Name_____ Birth Date_____

Mailing Address_____ City_____ State_____ Zip_____

Email_____ Phone_____

Emergency Contact_____ Phone_____

Occupation_____ Referred by_____

Receive Your Report (circle): In Person / Mail / Email

Last Thermogram_____ /_____ / _____

BREAST QUESTIONNARIE

Diagnosed with breast cancer? ❒Yes ❒No

If yes, when: _____ /_____ / _____

And type (circle):

Metatastic / Lymphatic Node Removal / Local

Diagnosed with other breast disease? ❒Yes ❒No

Biopsies and your findings? ❒Yes ❒No

Breast surgery / implants? ❒Yes ❒No

Mammogram last 12 months? ❒Yes ❒No

Total mammmograms: #_____

First mammmogram: _____ /_____ / _____

Contraceptive over 1 year? ❒Yes ❒No

Hormone therapy? ❒Yes ❒No

Doctors last breast exam: _____ /_____ / _____

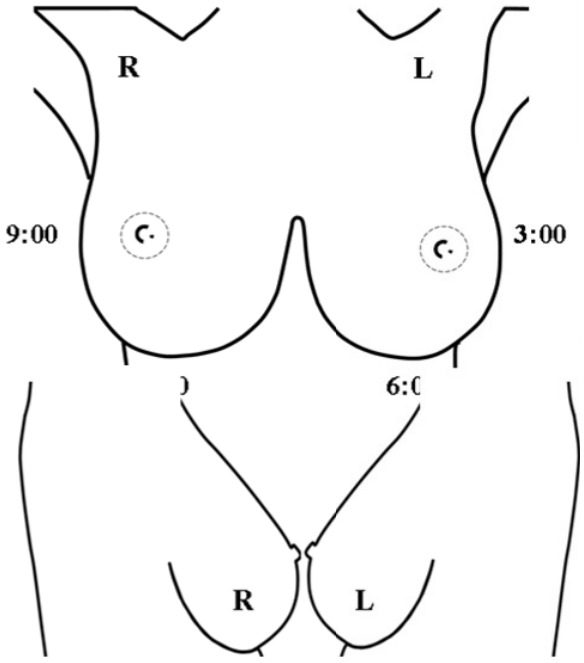
Monthly self breast exams? ❒Yes ❒No

Mestrual periods before age 12? ❒Yes ❒No

Menstrual period stopped after 50? ❒Yes ❒No

Total Births: #_____ Age of first born: _____

Breast symptoms in the last 6 months?
Please indicate the symptoms with the following symbols:
T - Tenderness
L - Lumps
D/T - Nipple Dimpling/Thickening
CS - Change in Size
NS - Nipple Secretion
B - Biopsy



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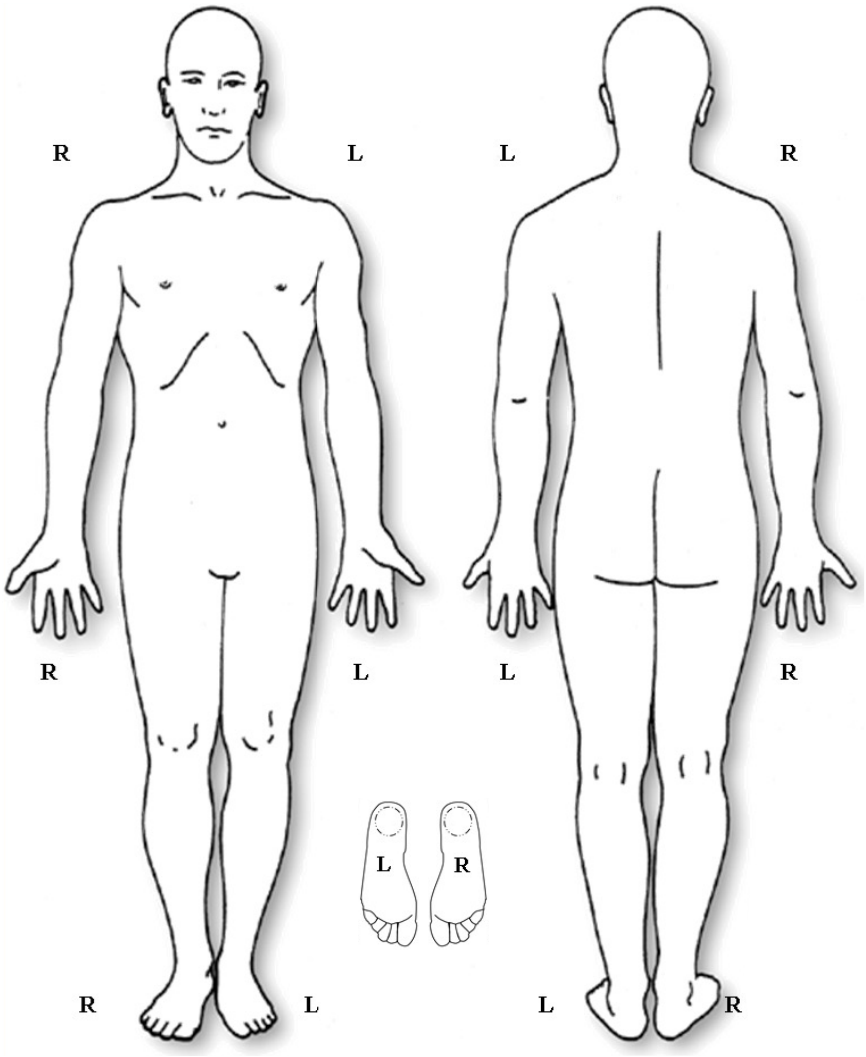
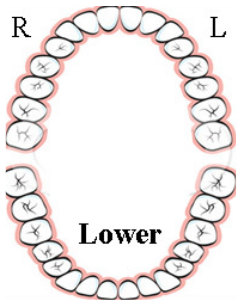


Body History
Please indicate the symptoms with the following symbols:
N - Numbness
S - Scars
M - Moles
F - Fractures
1-10 - Pain (10 being worst)
X - Surgeries or prior/current disease with a brief description.

Teeth/Gum History
Please indicate the symptoms with the following symbols:
RC - Root Canal
C - Crown
S - Surgery
MF - Mercury Fillings
O - Other



Current Issues / Concerns / Medications?

_____

_____

_____

_____

_____

I understand the report generated by my images is intended for use by trained healthcare providers to assist in evaluation, analysis and treatment. I understand the report is not intended for use by individuals for self-evaluation, diagnosis or treatment. I understand the report will not tell me whether I have an illness, disease or other condition but will be an analysis of the images with respect only to the thermographic findings of areas discussed in the report. By signing below, I acknowledge and certify that I have read and understand the statements above and consent to the examination. I also authorize the release of information and the receipt of information in the pursuit of comprehensive evaluation and treatment relating to the services provided by ***Complete Thermal Imaging, LLC.***

Patient Signature_____ Date_____

Signature Authorizing Payment

FOR OFFICE USE ONLY FIRST VISIT 3 MONTH 1 YEAR RECALL SUPER BILL

Description _____ Cost $_____

Payment Method: Check #_____ Check/Cash $_____

Credit Card # _____ Exp Date_____ CSV _____

Circle: VISA MASTERCARD DISCOVER

Billing Address (If different from previous page) _____