Thermography Of Miami, LLC

Patient Intake Form

Name: _____

D.O.B. ____/_____/_____. Age: _____. Sex: Male ___. Female ___.

Address: _____ Apt. No. _____

City: _____. State: _____. Zip: _____

Occupation: _____ Email: _____

Phone: Home: (____)_____ Work: (____)_____

Mobile: (____)_____ Leave message with results: Yes ___ No __

Reason for today's visit: _____

Current Symptoms: _____

_____

Current skin lesions/ locations: _____

Current Treatment / Medications: _____

_____

Previous Illnesses: _____

_____

Previous Surgeries / Injuries with dates: _____

_____

Do you want your report sent to your Health Care Provider: Yes ___ No ___

Health Care Provider's Name and Address: _____

_____

This information is confidential and correct to the best of my knowledge.

Signature: _____ Date: ____/_____/_____

For Office Use Only:

Patient ID #: _____

Report Ref. #: _____ BR1 BR2 BRA HB FB ROI _____

Location: _____ Scans uploaded: _____

Data updated: _____ Called: _____

Patient report sent: _____ Healthcare Provider report sent: _____

Payment: _____ Check No.: _____ Visa __ MasterCard __ Amex__ Discover__