Breast and Body Thermography

PATIENT INFORMATION SHEET

This information is confidential.

Name: ______________________________ **DOB:** ____________________

Address: ____

Phone: ________________________ **Cell:** ____________________

Email: ____

Medical History/Previous Illness:

Previous Surgery (Including Dental):

Current health problems or concerns:

Scar tissues/Skin Abnormalities:

Medications (Vitamins/Herbs):

Family History:

Other Treatment:

Current Doctor:

Address:

Phone #:

All information is correct to my knowledge.

I acknowledge I have received copies of brochures from ACCT (or read them on the website). I have reviewed the indications for Thermography as per the ACCT website. I understand that Thermography (DITI) is an adjunctive diagnostic tool and is not a stand alone diagnostic test. Verbal statements or opinions expressed by any staff or contractors of BB Thermography are null and void to the information provided by the ACCT. Thermography does not diagnose, treat, cure, or prevent any medical illness or disease.

Signed: ______________________________ **Date:** ____________________