River Of Life Wellness

Thermography Registration

First Name: _____ **Last Name:** _____ **DOB:** _____

Age: _____ **Sex** M ☐ F ☐ **Address:** _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Second Phone:** _____ **Email:** _____

May we leave you a message? Y ☐ N ☐ **Occupation:** _____

What are we seeing you for today? _____

Symptoms/Onset: _____

Treatment Received: _____

Please explain the dental work you have received (check all that apply):

☐ Root canal; how many and where? _____

☐ Crown; how many and where? _____

☐ Fillings; how many and where? _____

☐ Extractions (including wisdom); how many and where? _____

☐ Braces: _____

☐ Mouth trauma; please explain: _____

☐ Previous illness; please explain: _____

☐ Other screening or test results you have had in the last five years. _____

☐ Scars or tattoos; please explain: _____

Current medications and dose (please use back of sheet for more space to write, if needed)**:**

Medication name: _____Dose_____ Taken for: _____

Medication name: _____Dose_____ Taken for: _____

Medication name: _____Dose_____ Taken for: _____

Medication name: _____Dose_____ Taken for: _____

Do you want the results of you scan sent to your healthcare provider? Y ☐ N ☐

Clinic name, your doctor's full name, and clinic address: _____

_____

To the best of my knowledge, all information is correct (please sign):

Signed: _____ **Date:** _____

Disclaimer: River of Life Wellness does not claim thermography replaces mammography.

Office use only:

BR! BRW BRA FB UB LB ROI PT ID#_____ Rep. Ref #_____ Location_____
Referred by: _____ Next appt._____ EMI: _____ Rept. Sent_____
PT EM DR _____ Called _____ LM/TT Updated _____ Payment $_____ Ck#:_____
V MC D Ca Rcpt: Y / N mailed _____ Received: _____