

New England Clinical Thermography Incorporated

Patient Information Sheet

Last Name: _____ First: _____ MI: _____

DOB _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ E-Mail: _____

Occupation: _____

Previous Illnesses: _____

Current Health Problems: _____

Medications: _____

Other Treatment: _____

Current Doctor: _____

Address: _____

Phone: _____

How did you learn of imaging at this location? _____

This information is confidential.
All Information is correct to my knowledge.

Signed: _____ Date: _____