MIDWEST THERMOGRAPHY
SOLUTIONS

Patient Information Sheet

Name _____ Birthdate _____

Address_____

Phone _____ Email _____

Occupation_____ How did you hear of MTS?_____

Previous Illnesses:

Previous Surgeries:

Current Health Problems:

Medication _____

_____

Other Treatment _____

Current Doctor _____

Would you like a copy of the thermogram faxed to your doctor? YES _____ NO _____

Doctor's fax number_____

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

Signature _____ Date _____

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Privacy Policy effective as of _____/_____/_____
I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide **Midwest Thermography Solutions** with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

_____	_____	_____
Patient's Name (print)	Patient's Signature	Date

_____	_____
Authorized Facility Signature	Date