Infrared Regulation Thermometry
Confidential Patient Information
(PLEASE PRINT)

Patient Name _____ Date _____

☐ Male ☐ Female Date of Birth _____/_____/_____

Please list any current symptoms, medical conditions, or health concerns you may have:

_____

_____

MALES & FEMALES

Weight: _____ Height: _____ ☐ I am a smoker ☐ I smoked in the past 24 hours.

Within the past year, I have experienced the following (check all that apply):

☐ Digestive problems	☐ Eczema/hives/acne	☐ Joint Pain
☐ Vision/hearing	☐ Blood Pressure ☐ High ☐ Low	☐ Palpitations
☐ Sore muscles	☐ Shortness of breath/asthma	☐ Yeast Infections
☐ Low back pain	☐ Blackouts/Fainting	☐ Chronic Fatigue
☐ Urination problems	☐ Headaches/migraine	☐ other _____

☐ I am currently taking medications: Details: _____
☐ I still have my tonsils ☐ I still have my appendix ☐ I still have my gall bladder
☐ I have my wisdom teeth.
☐ I have dentures. ☐ Upper ☐ Lower ☐ Missing Teeth: Which teeth? _____
☐ I have a bridge or capped teeth. Which teeth? _____
☐ I have root canal teeth. Describe problems you may have had: _____
☐ I have silver amalgam fillings (dark or metal colored fillings).
☐ I consume alcohol: ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely
☐ I consumed alcohol or have taken recreational drugs in the past 24 hours. Details: _____
☐ I have had "recent" emotional upsets or traumas in my life. Details: _____
☐ I ate a light breakfast.
☐ I had caffeine this morning.
☐ I got a good sleep last night. I woke up today at: _____
☐ I am taking hormones: Details: _____ Oral Contraceptives: _____
☐ I have had hepatitis. Specify type: _____

FEMALES ONLY

Bra Size _____ Cup Size _____
☐ I am a new mother and currently nursing my child.
☐ I have a menstrual period. Indicate what day of your 28-day cycle you are in? _____
☐ I do not have a menstrual period ☐ I had a hysterectomy
☐ I have menstrual problems. Details: _____
☐ I am experiencing breast tenderness, discharge, etc. Details: _____
☐ I have received chemo or radiation. When? _____

_____
Specify the approximate date and location of any thermograms you've had before.

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Specify any hospitalizations, illness, implants or surgery, and any complications you may have had.

Specify the location of any scars you have.

Specify any bodily injuries you have had from a motor vehicle or other accident and when.

Specify any conditions you may have or had related to a specific organ of the body (e.g., heart, lungs, uterus, prostate, etc.)

Insurance

For insurance coverage, you can submit your sales receipt for reimbursement as we do not take insurance. On the receipt will be the following insurance codes:

CPT codes:
93740 Temperature gradient studies
93799 Unlisted cardiovascular procedure
76498 Unlisted radiological procedure (e.g., diagnostic, interventional)

ICD-9 codes:
V76.19 Breast screening
88.85 Breast thermography
88.81 Cerebral thermography
88.86 Blood Vessel thermography
88.89 Thermography of other sites

I understand that the AlfaSight 9000® System is not a primary diagnostic device as deemed by the U.S. Food and Drug Administration. Its purpose is to provide additional information for the physician or practitioner to aid in the integration of other tests and results in order to achieve better treatment outcomes, and is not intended as a sole diagnostic method for any disease or dysfunction. I agree to not hold Alfa Thermodiagnostics responsible for any decision I or my doctor make based on the results obtained.

I understand that this thermometry assessment, in and of itself, is simply an additional device to evaluate the balance and health of my body and is not meant to exclude other methodologies of cancer detection. I am ultimately responsible for payment to Dynamic Health and accept that this assessment may not be covered by my insurance company. Payment is due at the time of service. You will be given a receipt for your visit, which you can submit to your insurance company. If the insurance company does not pay for the services, Dynamic Health assumes no responsibility for reimbursement.

Signed (Patient Name) _____ Date _____