

Please check:

**FEMALE**  **MALE**

Title: Ms.  Mr.  Mrs.  Miss.

YEAR | MONTH | DAY

**BIRTH DATE:** \_\_\_\_\_

PATIENT: \_\_\_\_\_ FIRST NAME \_\_\_\_\_ LAST NAME \_\_\_\_\_ **What is your age?** \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ POSTAL CODE \_\_\_\_\_

HOME PHONE \_\_\_\_\_ DAYTIME PHONE \_\_\_\_\_

Please **PRINT** (Parent or Guardian Name if patient is under 19 years of age)

Title: Ms.  Mr.  Mrs.  Miss.

**IMPORTANT ALL METAL OBJECTS MUST BE REMOVED FROM HEAD AND NECK.**

Yes No

Do you (patient) have any illness that is contagious? (i.e. a cold etc.?)

If yes, please explain: \_\_\_\_\_

Do you (patient) have any head or neck injuries, special conditions or problems that we should be aware of?

If yes, please explain: \_\_\_\_\_

**Female Patients Only:**

Is there any possibility that you (patient) are pregnant?

If so, please inform the technician.

Thank you.