WILSON IMAGING CENTERS

Please take a moment to verify and complete the information below

DATE:

Referred By DR.

Patient's Name: TRACING DOB:

if Minor, Name of Responsible Party_____

Phone Number:_____

Address_____

City_____St_____Zip_____

During the previous 6 months, have you (patient) had any dental x-rays?

If yes, explain_____

Do You (patient) have any illness that is communicable?

If yes, explain_____

Do you (patient) have a LATEX ALLERGY? YES or NO

Do You have any injuries, special conditions that we should be aware of?

If yes, explain_____

Ethnic Background: This information is used to provide accurate

Cephalometric analalysis data. Please circle one:

African American Asian Korean Hispanic

American Indian Chinese Caucasian South Pacific

Female Patients Only: Is there any possibility that you (patient) are pregnant?

please check one: YES_____ No_____ Release signed if yes_____

********** **Please remove gum, removable partials, retainers,**

jewelry or any other metal objects from head and neck. ********

_____OFFICE USE ONLY_____

TI._____T.O._____Technician_____