LIGHTWAVE PATIENT TREATMENT NOTES

CLIENT'S NAME: _____

DATE OF BIRTH: _____

TREATMENT PLAN: _____

INITIAL CONSULTANT: _____

DATE: _____ TECHNICIAN'S INITIALS: _____ Treatment # _____

LIGHTWAVE SYSTEM: Unit serial # _____

RED/IR RED/BLUE ___PANEL ___ PAD SET(S) S/N: _____

Program Name:	Program No:	Duration:	Prep Area:	Pictures Taken:

Treatment notes:

DATE: _____ TECHNICIAN'S INITIALS: _____ Treatment # _____

LIGHTWAVE SYSTEM: Unit serial # _____

RED/IR RED/BLUE ___PANEL ___ PAD SET(S) S/N: _____

Program Name:	Program No:	Duration:	Prep Area:	Pictures Taken:

Treatment notes:

DATE: _____ TECHNICIAN'S INITIALS: _____ Treatment # _____

LIGHTWAVE SYSTEM: Unit serial # _____

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Program Name:	Program No:	Duration:	Prep Area:	Pictures Taken:

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DATE: _____ TECHNICIAN'S INITIALS: _____ Treatment # _____

LIGHTWAVE SYSTEM: Unit serial # _____

RED/IR RED/BLUE ___PANEL ___ PAD SET(S) S/N: _____

Program Name:	Program No:	Duration:	Prep Area:	Pictures Taken:

Treatment notes:

Client Name: _____ Date of Birth: _____