ROSEMARY HEIGHTS
DENTAL

## 3-D CONE BEAM COMPUTED TOMOGRAPHY (CBCT) 10x10 FOV

PATIENTS NAME: _____

DATE OF BIRTH: _____ TELEPHONE: _____

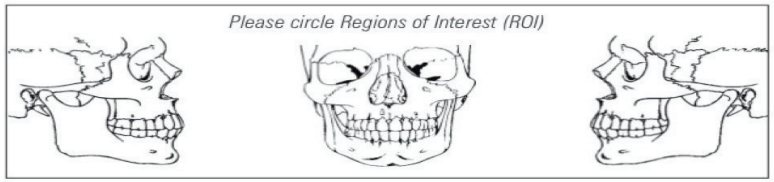
IMAGES REQUIRE BY (DATE): _____

PREFERRED METHOD OF RECEIVING THE SCAN: ☐ DROPBOX ☐ CD MAILED

**PLEASE CHECK DESIRED PROCEDURES:**

AREA: ☐ SINGLE JAW ☐ BOTH JAWS ☐ REGION TO MUST INCLUDE:

FORMAT: ☐ VIEWER + DICOM ☐ DICOM (RAW IMAGES) ONLY




**Please, circle the area of concern**

| R | | | | | | | | | | | | | | | | L |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| | 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |

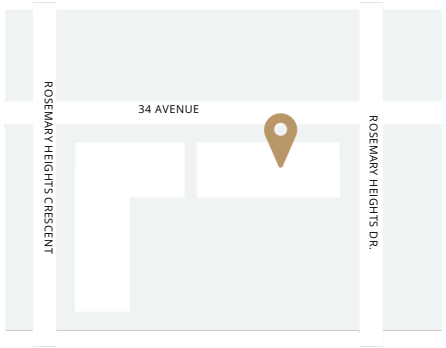
SPECIAL INSTRUCTIONS: _____

_____

_____

DR. NAME: _____ CLINIC: _____

DR. SIGNATURE: _____ DATE: _____

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WE WILL CONTACT THE PATIENT VIA PHONE NUMBER PROVIDED UNLESS SPECIFIED OTHERWISE.