3-D Cone Beam Computed Tomography (CBCT) 10x10 FOV

Patients Name: ______________________________

Date of Birth: ____________________ **Telephone:** ____________________

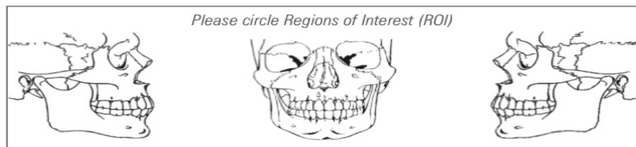
Appt. Date: ____________________ **Appt. Time:** ____________________

Images required by (date) : ______________________________

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:

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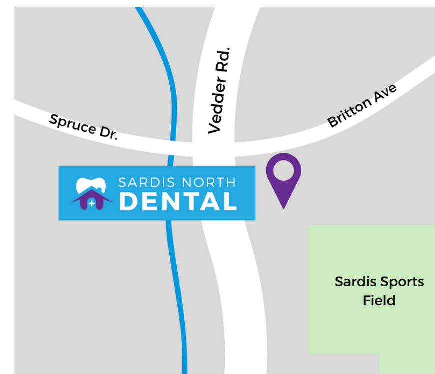
Dr. Name: ____________________ **Clinic:** ____________________

Dr. Signature: ____________________ **Date:** ____________________



7056 Vedder Road, Suite #201, Chilliwack, BC, V2R 1E3| (604) 858-5001

Please email the filled form and also have patient bring it to the appointment.