FRASERVIEW DENTIST

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

Patients Name: _____

Date of Birth: _____ **Telephone:** _____

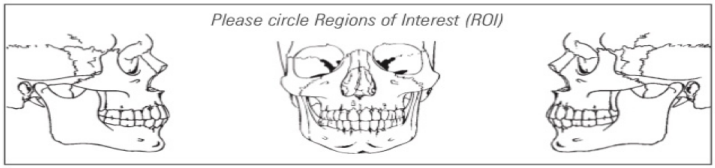
Appt. Date: _____ **Appt. Time:** _____

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

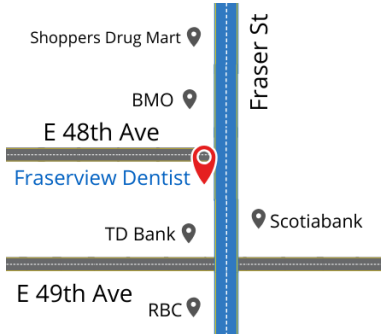
Special instructions:

_____

_____

Dr. Name: _____ **Clinic:** _____

Dr. Signature: _____ **Date:** _____



6403 Fraser Street, Vancouver BC, V5W 3A6 604-325-1711

Please call to book your appointment and make sure to bring this form with you.