

Patient's Name:..... Exam Date:.....

SCANNING

- Implant Survey
- Maxillary Arch Tooth #.....
- Mandibular Arch Tooth #.....
- Cone Beam Scan Only (DICOM)
- Pathology Tooth #.....
- Patient to be imaged with Scan Prosthetics
- Maxilla Mandible
- Impacted Teeth Survey Tooth #.....
- TMJ Survey Closed only Open/Closed
- Sleep Apnea
- Sinus Study
- Radiologist report

PROCESSING

Area of Interest

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Format Options (please check)

- Images Burned to CD (pdf)
- Images Emailed Urgent (same day by internet download)
- Images Printed

Notes / Diagnosis:

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For radiologist report include relevant history, reason for scan, special instructions and other comments.

Dentist Information:

Dentist:

Address:

Phone: Email:

Signature: