

**Park X-Ray Laboratory**



Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_

Appointment Date: \_\_\_\_\_ Time: \_\_\_\_\_ Fee: \_\_\_\_\_

**i - CAT 3D VOLUMETRIC SCAN**

- Implant Volumetric CT Scan
- TMJ Volumetric CT Scan
- Volumetric CT Scan
- Radiographic Report
- Digital Panoramic

**ORTHODONTIC SURVEYS**

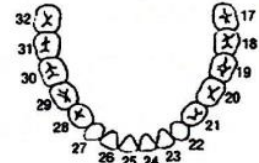
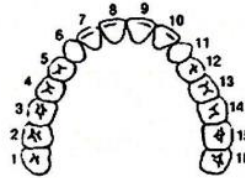
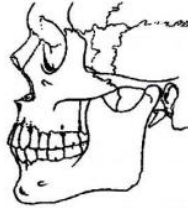
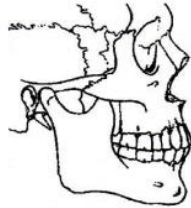
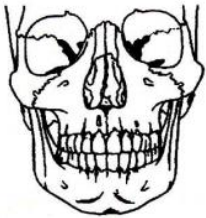
- Beginning
- Progress
- Final

**GENERAL PROCEDURES**

- Lateral Cephalometric
  - o Tracing \_\_\_\_\_
  - Black | Blue | Red | Green
- Panoramic Film
- PA Cephalometric
- AP Cephalometric
- Carpal Index (left)
- Digital Color Photographs
  - o Chart Photos



**Please circle the tooth numbers and region of interest.**



Special Instructions: \_\_\_\_\_

Print Doctor Name: \_\_\_\_\_ Date: \_\_\_\_\_

**ATTENTION PATIENTS/PARENTS**

- 1) We do not bill insurance for payment.
- 2) Payment is required at time of appointment.
- 3) Please bring this referral slip with you.
- 4) 24 hour notice of cancellation is appreciated.
- 5) See map below for directions.
- 6) Patients later than 15 minutes may be asked to reschedule.

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**(408) 293-9351**  
**[www.parkxraylab.com](http://www.parkxraylab.com)**

