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

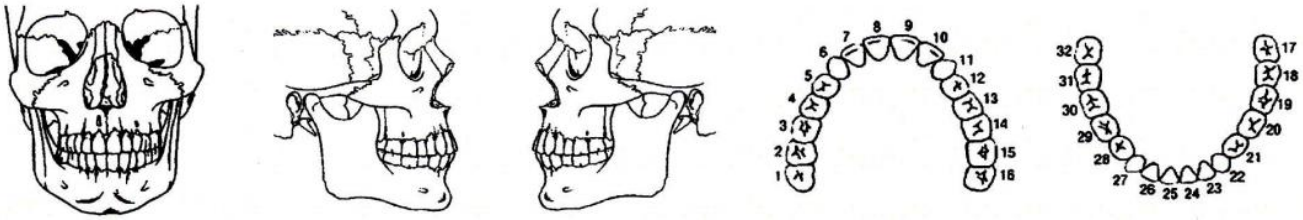
ORTHODONTIC SURVEYS

- ☐ Beginning
- ☐ Progress
- ☐ Final

GENERAL PROCEDURES

- ☐ Lateral Cephalometric
  - Tracing _____
    Black | Blue | Red | Green
- ☐ Panographic Film
- ☐ PA Cephalometric
- ☐ AP Cephalometric
- ☐ Carpal Index (left)
- ☐ Digital Color Photographs

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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