
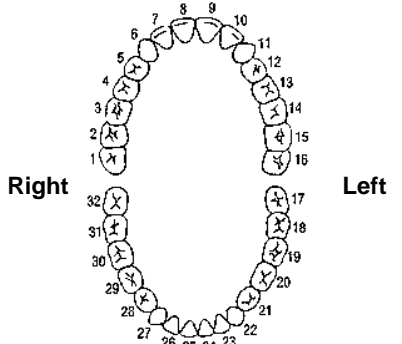


Please see back for map 
 & important patient information

To schedule an appointment, please phone:
(714) 964-6440

DATE: _____ TIME: _____ FEE DUE AT TIME OF SERVICE \$ _____

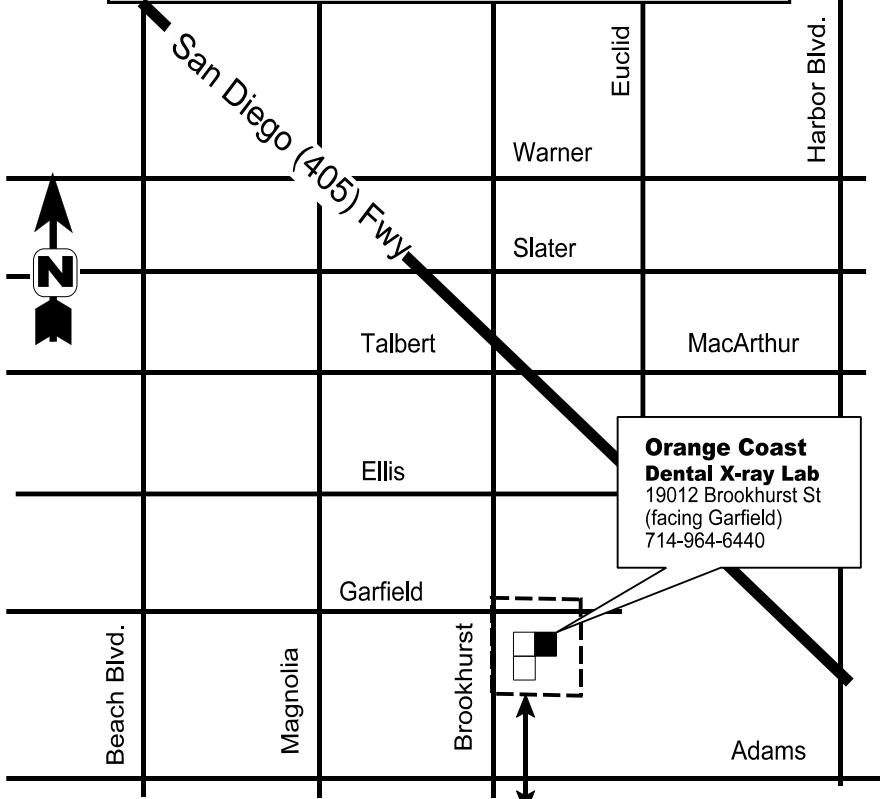
NAME: _____ DOB: _____

SURVEYS	Cone Beam Volumetric Scan (CBCT)
<i>(Standing Orders on file)</i>	
<input type="checkbox"/> 1-Orthodontic Survey <input type="checkbox"/> Begin. <input type="checkbox"/> Progress <input type="checkbox"/> Final	<input type="checkbox"/> 17-TMJ - closed (L&R) <input type="checkbox"/> -add CD w/data & reports
<input type="checkbox"/> 2-Pan-Survey <input type="checkbox"/> Begin. <input type="checkbox"/> Progress <input type="checkbox"/> Final	<input type="checkbox"/> 18-TMJ - closed & wide open (L&R) <i>(all data & reports included on CD)</i>
<input type="checkbox"/> 3- _____	<input type="checkbox"/> 19-TMJ - add'l view _____
CEPHALOMETRICS	<input type="checkbox"/> 20-Implant - <input type="checkbox"/> Maxilla <input type="checkbox"/> Mandible
<input type="checkbox"/> 4-Lateral Skull (<i>Lateral Ceph</i>) <input type="checkbox"/> Tracing of Lateral Ceph <input type="checkbox"/> Begin. <input type="checkbox"/> Progress <input type="checkbox"/> Final	<input type="checkbox"/> 21-Impacted tooth # _____
<input type="checkbox"/> 6-PA Skull (<i>Frontal Ceph</i>) <input type="checkbox"/> Tracing of PA Ceph <input type="checkbox"/> Begin. <input type="checkbox"/> Progress <input type="checkbox"/> Final	
INDIVIDUAL PROCEDURES	
<input type="checkbox"/> 7-Entire Mouth (<i>pa's & bw's</i>)	
<input type="checkbox"/> 8-Anterior Periapicals (<i>U&L</i>)	
<input type="checkbox"/> 9-Bitewings	
<input type="checkbox"/> 10-Panoramic (<i>single film with copy</i>)	
<input type="checkbox"/> 11-Occlusal - Maxillary	
<input type="checkbox"/> 12-Occlusal - Topographical 90°	
<input type="checkbox"/> 13-Occlusal - Mandibular	
<input type="checkbox"/> 14-Carpal Index (<i>Wrist Film</i>)	
<input type="checkbox"/> 15-Burn x-rays & photos to CD	
<input type="checkbox"/> 16-Photographs - color prints	
	
	voxel resolution preference <input type="checkbox"/> .4mm <input type="checkbox"/> .3mm <input type="checkbox"/> .25mm <input type="checkbox"/> _____
	SPECIAL INSTRUCTIONS

	Dr. _____

IMPORTANT PATIENT INSTRUCTIONS

- 1) Please bring this prescription slip to your appointment.
- 2) Payment is required when services are rendered.
- 3) Please have hair combed and teeth brushed for photographs.
- 4) Patients more than 10 min. late may be asked to reschedule.
- 5) 24 hour prior notice of cancellation is appreciated.



Orange Coast
Dental X-ray Lab
 19012 Brookhurst St
 (facing Garfield)
 714-964-6440

