3-D DIGITAL IMAGING

Today's Date :

Patient's Name :

Phone :

Images required by (date) :

Please check desired procedures :

- [ ] Implant Computed Tomography (Please state tooth #'s)
- [ ] DICOM File

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

CD Rom with viewer will be sent to your office within one week.

- [ ] BITES Institute member

Office Stamp (Address & Phone)

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