Park X-Ray Laboratory

Patient Name: _____ Age: _____

Appointment Date: _____ Time: _____ Fee: _____

i – CAT 3-D Volumetric Scan

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

ORTHODONTIC SURVEYS

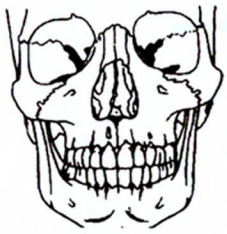
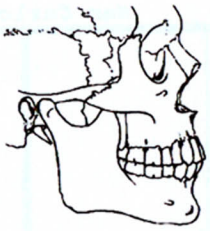
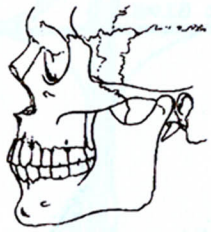
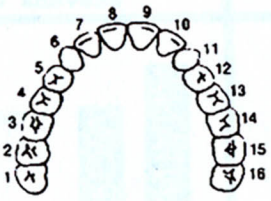
☐ Beginning ☐ Progress ☐ Final

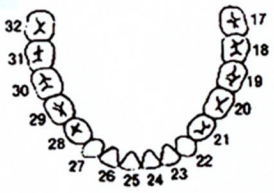
i-CAT®

GENERAL PROCEDURES

1. ☐ Lateral Cephalometric
   ☐ Tracing _____
   o Black o Blue o Red o Green
2. ☐ Panographic Film
3. ☐ Full Mouth Series
4. ☐ Occlusals: o Maxillary o Mandibular
5. ☐ P.A. ☐ A.P. Cephalometric
6. ☐ Carpal Index (left)
7. ☐ Digital Color Photographs
   o Chart Photos

Please circle the tooth numbers & Region of Interest



Special instructions: _____

(Print Name): Dr. _____ Date: _____

ATTENTION PATIENTS/PARENTS:

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

2074 Forest Avenue, Suite 5
San Jose, CA 95128
(408) 293-9351
www.parkxraylab.com