

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

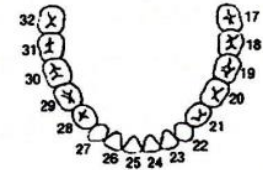
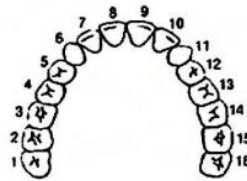
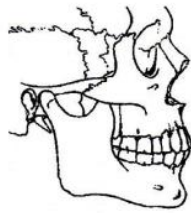
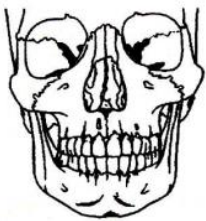
- Beginning
- Progress
- Final

GENERAL PROCEDURES

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