NEW WESTMINSTER
CITY DENTIST

3-D Cone Beam Computed Tomography (CBCT) 10x10 FOV

Patients Name: _____

Date of Birth: _____ **Telephone:** _____

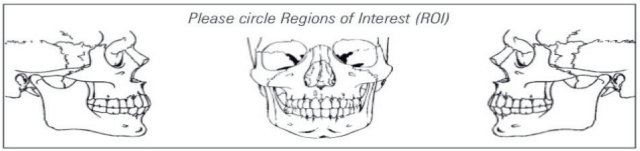
Appt. Date: _____ **Appt. Time:** _____

Images required by (date) : _____

Please check desired procedures:

Area: ☐ Single Jaw ☐ Both Jaws ☐ Region to must include: _____

Format: ☐ Viewer + DICOM ☐ DICOM (raw images) only



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

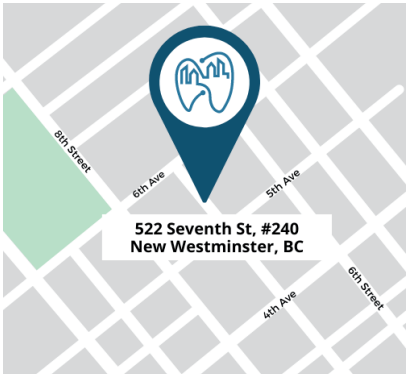
Special instructions:

_____

_____

Dr. Name: _____ **Clinic:** _____

Dr. Signature: _____ **Date:** _____



info@nwcitydentist.com | 522 Seventh St, #240, New Westminster, BC V3M 5T5

Please email the filled form and also have patient bring it to the appointment.