NEW WESTMINSTER
CITY DENTIST

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

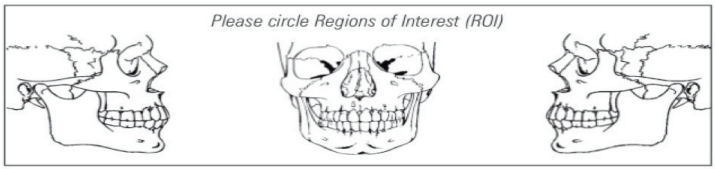
Patients Name: _____

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

Images required by (date) : _____

Best email address to send the scan to: _____

☐ **Region to must include:** _____ ☐ **Sinus Ostium (OMC):** _____



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:** _____

522 Seventh St, #240, New Westminster, BC V3M 5T5 | (604) 524-1311

Please email the completed form to info@nwcitydentist.com