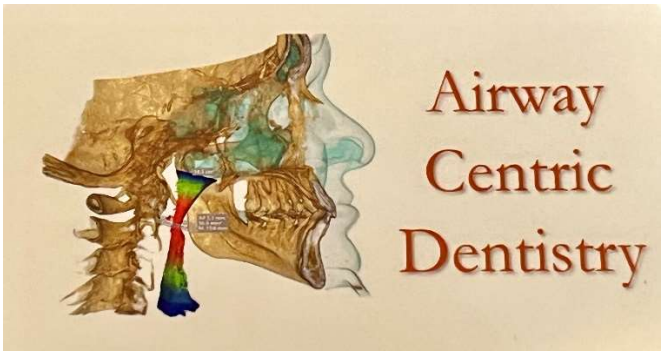

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Script for CBCT Dental Scan

Patient Name: _____

Patient DOB: _____

Phone #: _____

Email: _____

- Upload to: skalffanalysis@gmail.com

Treatment Instructions/Recommendations:

Please take CBCT Scan as maximum Field of Vision in centric occlusion. *

_____

Reason for Scan/Additional Comments:

_____

_____

_____

Thank You,

Som Gupta, DDS