



APPOINTMENT IS NECESSARY: CALL OR BOOK ONLINE [WWW.DENTXIMAGING.COM](http://WWW.DENTXIMAGING.COM)

PLEASE BRING THIS PRESCRIPTION WITH YOU TO YOUR APPOINTMENT

TEL: 818.239.5333

FAX 818.975.5333

1323 N. SAN FERNANDO BLVD.

BURBANK, CA 91504

DENTXIMAGINGCENTER@GMAIL.COM

WWW.DENTXIMAGING.COM

PATIENT NAME \_\_\_\_\_ DOB \_\_\_\_\_

REFERRING DOCTOR & PHONE NUMBER \_\_\_\_\_

PROVIDE EMAIL ADDRESS FOR DIGITAL COPIES \_\_\_\_\_

BILL TO ☐ DOCTOR ☐ PATIENT

PAYMENT IS DUE WHEN SERVICES ARE RENDERED

## X-RAYS

- ☐ ORTHO SURVEY ☐ BEG ☐ PROG ☐ FINAL
- ☐ PANORAMIC FILM ☐ DUPLICATE
- ☐ LATERAL CEPH ☐ TRACING (TYPE \_\_\_\_\_)
- ☐ PA SKULL ☐ AP SKULL ☐ TRACING
- ☐ CARPAL INDEX (WRIST)
- ☐ CLINICAL PHOTOGRAPHS
- ☐ BITEWINGS
- ☐ PERIAPICALS

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16		
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8		
RT	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8	LT
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

## CT SCAN / CONE BEAM 3D i-CAT

- ☐ IMPLANTS ☐ MAXILLA ☐ MANDIBLE
- ☐ CD ☐ PRINTED COPY ☐ EMAIL
- ☐ TMJ CLOSED ☐ TMJ OPEN ☐ OTHER
- ☐ RADIOLOGIST REPORT

SPECIAL INSTRUCTIONS



FOR MORE INFORMATION ABOUT OUR SERVICES, SCHEDULE APPOINTMENTS & GET PRESCRIPTIONS, CLICK ON THE QR CODE