UCLA SCHOOL OF DENTISTRY

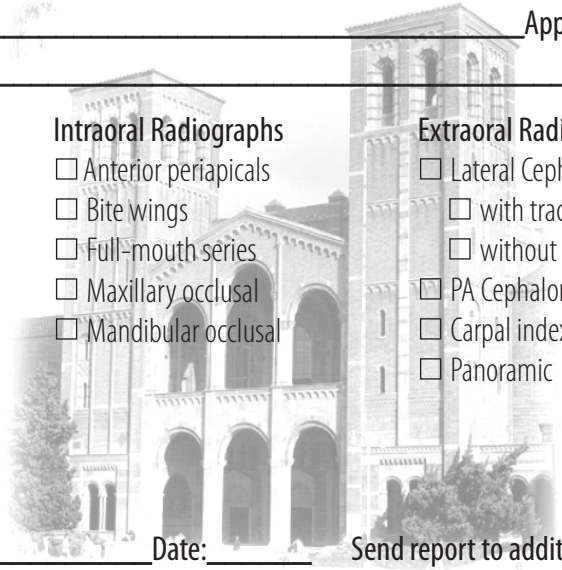
Dental Radiology Practice

10-165 CHS, 10833 Le Conte Ave. Los Angeles, CA 90095-1668
Phone: (310) 825-5634 Fax (310)206-2748

Please call for an appointment. Payment is required when services are rendered.

Patient:_____ Appt. Date/Time:_____

Clinical Diagnosis: _____



Cone-Beam CT

☐ Morita ☐ Newtom

- ☐ TMJ
- ☐ Maxillary Implants
- ☐ Mandibular Implants
- ☐ Orthodontic series
- ☐ Cracked tooth survey
- ☐ Endodontic survey
- ☐ DICOM Data
- ☐ Other_____

Intraoral Radiographs

- ☐ Anterior periapicals
- ☐ Bite wings
- ☐ Full-mouth series
- ☐ Maxillary occlusal
- ☐ Mandibular occlusal

Extraoral Radiographs

- ☐ Lateral Cephalometric
  - ☐ with tracing
  - ☐ without tracing
- ☐ PA Cephalometric
- ☐ Carpal index
- ☐ Panoramic

Photographs

- ☐ Facial
- ☐ Intraoral

Doctor's Signature:_____ Date:_____

Doctor's Name:_____

Send report to additional doctor:

Name:_____

Address:_____

_____