

## 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	):		ш
Please circle Regions of Interest (ROI)		Please, circle the a	area of concern	
	SO E O O	87654321	12345678	
		87654321	12345678	
Special instructions:			Shoppers Drug Mart 🗣	raser St
			вмо 🗣	Fras
			E 48th Ave	
Dr. Name:	Clinic:		Fraserview Dentist	
Dr. Signature:	Date:		TD Bank 🗣	Scotiabank
6403 Fraser Street, Vancouver BC, V5W 3A6   (604) 325-17	11		E 49th Ave	

Please email the completed form to info@fraserviewdentist.com