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

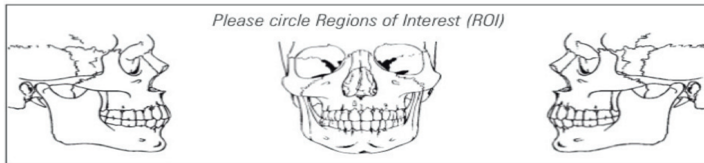
Patients Name: ____

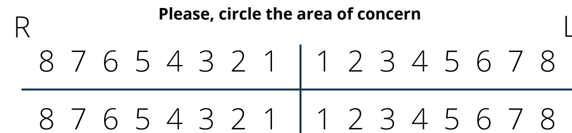
Date of Birth: ______________________ **Telephone:** ______________________

Images required by (date) : ____

Best email address to send the scan to: ____

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





Special instructions:

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Dr. Name: ______________________ **Clinic:** ______________________

Dr. Signature: ______________________ **Date:** ______________________

6403 Fraser Street, Vancouver BC, V5W 3A6 | (604) 325-1711

Please email the completed form to info@fraserviewdentist.com