ORTHODONTIC SURVEYS

☐ Beginning  ☐ Progress  ☐ Final
☐ Full mouth series (14 PA’s)
☐ Periapical (Specify): ____________________________
☐ Bitewings  ☐ Two  ☐ Four
☐ Lateral Ceph
☐ Post - Ant Ceph
☐ Carpal Index
☐ Photographs
☐ Other (Specify): __________________________

Panoramic views:
☐ Standard (w/ condyles)
☐ Orthogonal (w/o condyles)

TMJ series:
☐ 2 lateral views (closed)
☐ 4 lateral views (closed & open)
☐ 6 lateral views (closed, rest, open)

DENTAL IMPLANT / WISDOM TEETH / ENDO 3D SURVEYS

Please indicate by tooth number the specific areas to be imaged:

R

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

L

Is a stent with markers provided?  ☐ YES  ☐ NO

☐ UR  ☐ UL  ☐ Upper Full Arch
☐ LR  ☐ LL  ☐ Lower Full Arch

Please check below how you would like to receive your survey

☐ CD (DICOM file, mail/cloud)  ☐ Mandibular Canal Mapping
☐ Printed Views (mail/email)  ☐ Maxillary Sinus Floor Mapping
☐ Radiology Report (mail/email)  ☐ Endo Mode CBCT

Special Instructions: _________________________
______________________________
______________________________
______________________________

Signature:

• Please bring this prescription to your appointment.
• We can not provide service without the prescription.
• Patients under 18 are required to have this form filled out and signed by a parent or guardian.
• Payment is required at the time of your visit.

Signature by patient, parent or responsible party indicates permission has been given to take images as indicated on this prescription, and their release to doctor requesting them.

Signature: __________________________
Date: __________________________