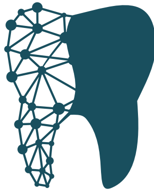

DENTAL CT LAB
11980 San Vicente Blvd. Suite 619
Los Angeles, CA 90049
(310) 337 - 0000
www.dentalctlab.com

CAPTURING THE ENTIRE ORAL-MAXILLOFACIAL REGION IN 3D CBCT

GALILEOS COMFORT +

PATIENT INFORMATION

LAST NAME, FIRST NAME: ____________________

DATE OF BIRTH: ____________________

ANATOMY TO BE SCANNED

☐ MAXILLA ☐ MANDIBLE ☐ BOTH ☐ TMJ ☐ QUADRANT ______

DIAGNOSITC OBJECTIVE

☐ MEASUREMENTS FOR IMPLANT SITE (LIST TOOTH #_______)

☐ TEETH (#) / QUADRANT (#) / ARCH (EVAL) _______

☐ PATHOLOGY EVALUATION (LIST TOOTH #_______)

☐ MAXILLARY SINUS EVALUATION (RIGHT OR LEFT)

☐ RADIOGRAPHIC STENT PROVIDED

☐ ORTHODONTICS

☐ ____________________

REFERRING DOCTOR

NAME (FIRST AND LAST): ____________________

OFFICE PHONE NUMBER: ____________________ (FLAT FEE $400)