



MODESTO MAXILLOFACIAL RADIOLOGY

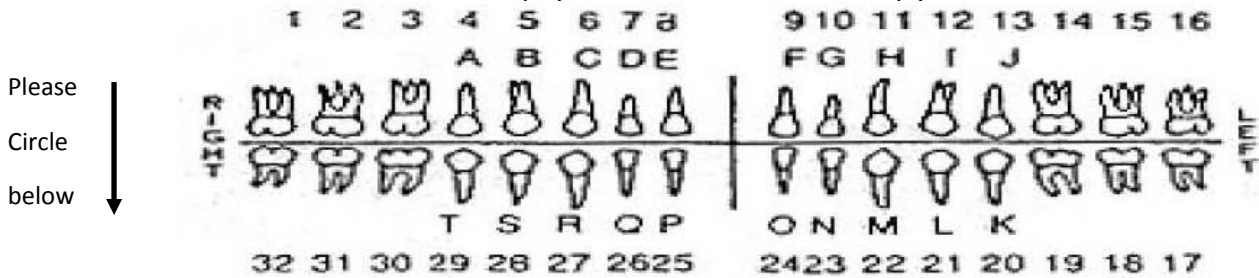
1601 Mc Henry Village Way, Ste 6, Modesto, CA 95350
Phone: 209-522-8311 Fax: 209-522-8317

Patient: _____ DOB: _____

Appointment Date: _____ Hour: _____

****FEE: _____ FEES ARE PAYABLE AT THE TIME OF APPOINTMENT**

This is a *prescription* ~ CA State Law requires this order to be present at the time of appointment.
Insurance payments will be refunded by your carrier.



2D Digital Imaging

1. Lateral Cephalometric
2. Cephalometric Tracing
3. PA Cephalometric
4. Panoramic
5. Photographic Survey
6. Wrist/Carpel Index
7. Cervical Spine Series
8. Duplications

- Print
 CD
 E-Mail

3D – Cone Beam Scan

9. TMJ With Report W/App
10. Implant—Site # _____
11. Impacted Cuspids
12. 3rd Molar/Nerve Relationship
13. Sinus
14. Location of Cysts or Lesions
15. Airway Study
16. Any other Structure w/in the Scan
17. Implant Conversion
18. 3D Dolphin Movie
19. E-MAIL Records Only-No prints
20. Radiographic Report

Additional Instructions: _____

**Referred By Dr. _____

Parent Signature: _____ MAP

Please **Remove All Jewelry** from the neck up prior to appointment.