

SUMAS MOUNTAIN VILLAGE DENTAL

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



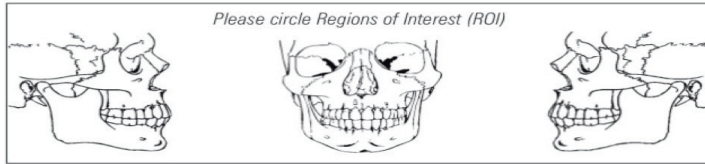
Patients Name: _____

Date of Birth: _____ Telephone: _____

Images required by (date) : _____

Best email address to send the scan to: _____

Region to must include: _____ Sinus Ostium (OMC): _____



Please, circle the area of concern

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	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8	

Special instructions:

Dr. Name: _____ Clinic: _____

Dr. Signature: _____ Date: _____

110 - 2362 Whatcom Road, Abbotsford, BC, V3G 0C1 | (604) 853-3305

Please email the completed form to info@sumasmountaindental.com

