

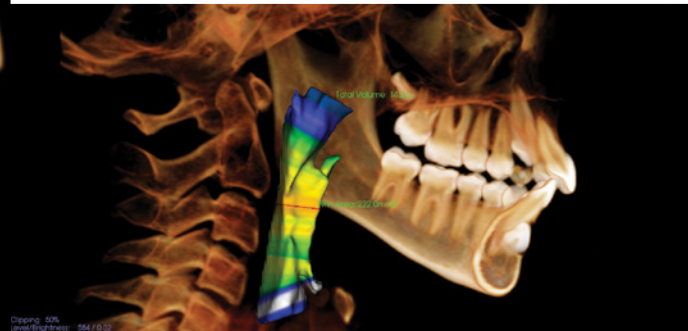
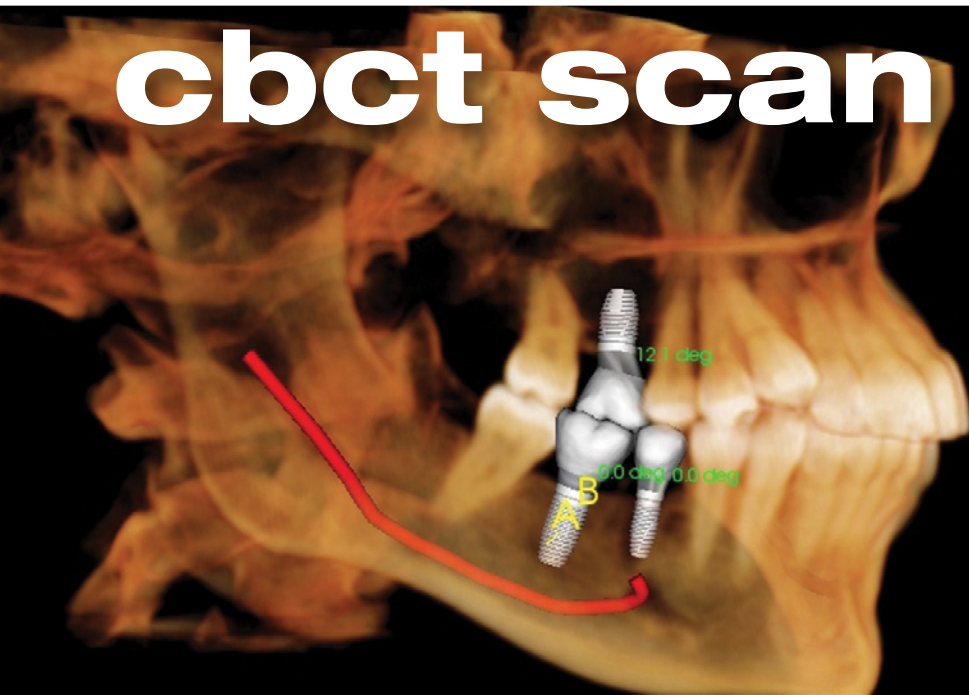
LAKES  
oral &  
maxillofacial  
surgery p.c.

**Jeffrey S. Cohen, DDS**  
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**cbct scan**





# cbct scan

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

Requested by Dr. \_\_\_\_\_

## Format/ Image Delivery Preference

CD  Printed  Emailed

Give to Patient

Email Report to: Email Address \_\_\_\_\_

Or Mail by USPS to:

## Area of Interest

Full Field Scan  Partial Field Scan

Maxilla  UR  U Ant  UL  Mandible  LR  L Ant  LL

Site / Tooth #: \_\_\_\_\_

## Reason for Referral

Implant  Impaction  Pathology  TMJ  Lateral Cephalogram

Airway  Sinuses  Supernumerary  Trauma  Other

## Comments

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Doctor's Signature \_\_\_\_\_

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SCAN WITH PHONE  
FOR MAP AND DIRECTIONS