WESTSIDE IMAGING CENTER

13821 N. 35th Drive Suite #3
Phoenix, AZ 85053
P: (602) 843-8008
F: (602) 863-3412

Patient's Name: _____

Date of Birth: ____/ ____/ ____ Age: _____

Appointment Date: ____/ ____/ ____ Time: _____

Fee: _____

3-D CONEBEAM CT (Includes PRINTS & CD)

- ☐ TMJ Limited (TMJ, Axial & Coronal Slices, Panoramic & Airway)
- ☐ TMJ Study & TMJ Open
- ☐ Implant (with Pan) Teeth # _____
- ☐ Impacted (with Pan) Teeth # _____
- ☐ Third Molar Evaluation
- ☐ Area of Focus _____
- ☐ ORAL RADIOLOGIST'S REPORT $75.00

1. Please bring prescription slip with you
2. Fees for service is due at time of appointment
3. Patients are seen by appointment only
4. Please remove all jewelry from head or neck for appointment

REFERRED BY: _____

PHONE: _____ DATE: _____