

**BROCKTON
DENTAL
X-Ray
LAB., INC.**

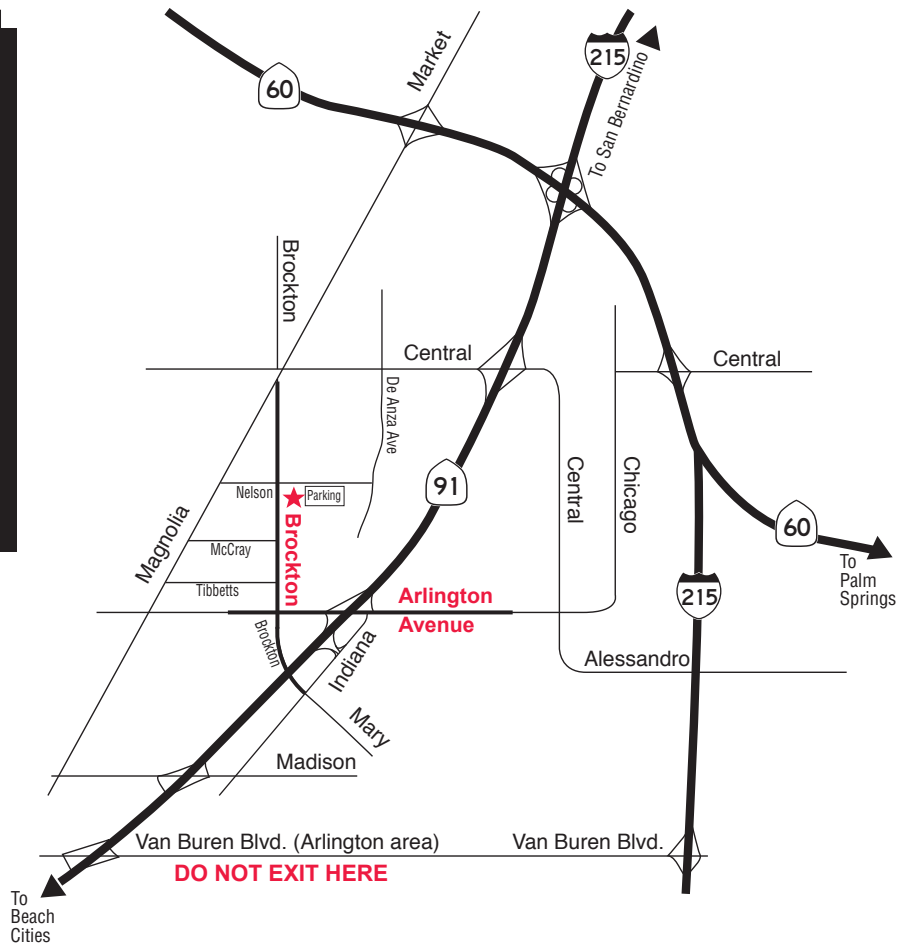
(951) 682-7505

Suite 3 ~ Second Floor

6800 BROCKTON AVE., SUITE 3
RIVERSIDE, CALIFORNIA 92506

E-Mail:
bdxl@sbcglobal.net

Website:
www.bdxlinc.com



*** PLEASE CALL TO SCHEDULE AN APPOINTMENT ***

*** BRING THIS LAB SLIP TO APPOINTMENT ***

BROCKTON DENTAL X-RAY LAB, INC.

6800 Brockton Ave, Ste 3 (upstairs) • Riverside, CA 92506 • **(951) 682-7505**

FAX (951) 682-7506

Website: www.bdxlinc.com **Map On Back**

PATIENT _____ DOB _____

APPT. DATE / /	TIME
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2D IMAGING:

ORTHODONTIC SURVEYS
 BEGINNING PROGRESS FINAL

PANORAMIC

PANORAMIC SURVEY (Inc. Anteriors, Bitewings + Duplication)

ADULT ENTIRE MOUTH (Inc. Bitewings + Duplication)

BITEWINGS

MAXILLARY OCCLUSAL MANDIBULAR OCCLUSAL

CEPHALOMETRIC PROFILE Tracing _____

Lips at Rest Lips Together

POSTERIOR-ANTERIOR SKULL Tracing

CLINICAL DIGITAL PHOTOGRAPHS (3 facial + 5 teeth)

3D IMAGING:

TMJ SERIES Open Closed

IMPLANT SERIES MX ARCH MD ARCH
 Right Left Right Left

AIRWAY SERIES

SURGICAL GUIDE (Blue Mousse bite needed)

CUSTOM SIMPLANT CONVERSION

RADIOLOGIST REPORT (recommended)

CINEX (Motion X-Ray) TMJ SERIES AIRWAY SERIES

RIGHT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	LEFT
	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8	
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

SURVEY DELIVERY METHOD: E-mail Dicom CD Printouts

3D INTRA ORAL SCAN

INVISALIGN

IMPLANT

VIRTUAL MODELS

OTHER:

SPECIAL NOTES:

PAYMENT RESPONSIBILITY
 Doctor Patient (Fee: \$ _____)

Referred By: _____
 Doctor's Name or Dental Group