

WHITTIER DENTAL IMAGING LLC

12468 Washington Blvd. Whittier, CA 90602

Please Call for an appointment: 562-907-5590 • *Hablamos Español*

WHITTIERDENTALIMAGING.COM

Patient's Name: _____

Date of Appointment: _____ Time: _____

1. ☐ ORTHODONTIC SURVEY (Requirements on file)
☐ Beginning ☐ Progress ☐ Final

2. ☐ PANORAMIC
(One Film)

3. ☐ PHOTOGRAPHS

4. ☐ CEPHALOMETRIC PROFILE ☐ Tracing

5. ☐ CEPHALOMETRIC P. A. ☐ Tracing

6. ☐ CARPAL INDEX (Wrist)

7. ☐ PANORAMIC TMJ ☐ Open ☐ Closed

8. ☐ DIGITAL INTRA ORAL SCAN

9. ☐ CBCT - FULL SKULL (15.4 x15.4 cm)

10. ☐ CBCT (15.4 x 8 cm) ☐ Maxillary ☐ Mandible

11. ☐ OTHER AREAS INDICATED

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

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12. ☐ CBCT TMJ ☐ Open ☐ Closed

13. ☐ ORTHODONTIC CBCT SCAN (Includes: Ceph profile & Tracing)

14. ☐ RADIOLOGIST REPORT

15. ☐ CHIROPRACTOR CBCT

If you are more than 10 min. late you may be rescheduled.

Referred by Dr. _____

Payment is due at time of appointment. Please bring this referral with you.



Whittier Dental Imaging

12468 Washington Blvd. Whittier, CA 90602

(In the east building of the medical plaza)

Phone: (562) 907-5590

Email: info@whittierdentalimaging.com

Web: www.whittierdentalimaging.com

- Please bring this prescription to your appointment.
- Patients under eighteen are required to have this form filled out and signed by a parent/guardian.
- Please brush teeth, remove head & neck jewelry.
- Remove non-permanent appliances such as retainers, partials, etc.
- Payment is required at the time of your visit. We are happy to provide you with the information required by your insurance carrier for possible reimbursement.
- Please inform tech if patient might be pregnant

Patient's Name (please print): _____

Birth Date: _____ Age: _____ Phone number: _____

Email: _____

Signature by parent or responsible party indicates permission has been given to take images as indicated on this prescription, and their release to doctors requesting them.

Signature: _____ Date: _____