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PATIENT NAME \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_ TIME: \_\_\_\_:\_\_\_\_

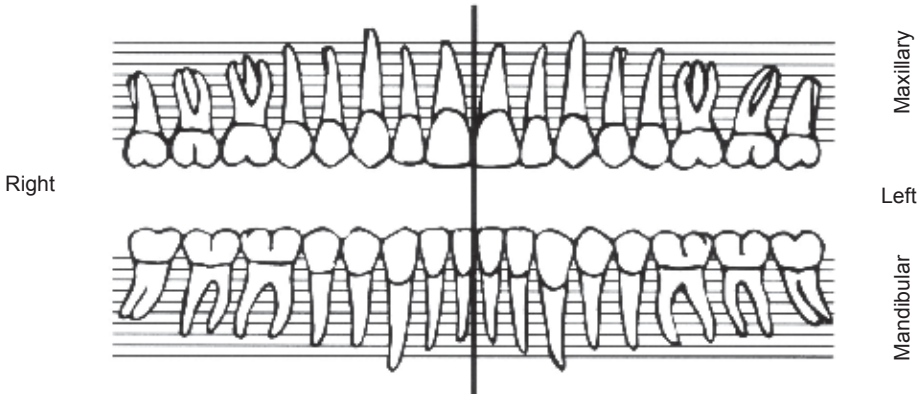
CLINICAL HISTORY:

**COMPUTED TOMOGRAPHY (DENTALS CAN)**

(Utilizing Columbia Scientific IM/PLANT Software)

- Maxilla
- Mandible

Other: \_\_\_\_\_



Check here for NYU

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

Images on:  CD  Zip Disk  Film  Paper

Send to:

Address: \_\_\_\_\_

Fax Report:  Yes  No (Fax Number): (\_\_\_\_)-\_\_\_\_-\_\_\_\_

E-mail Report:  Yes  No (Email Address) \_\_\_\_\_