



**SmartScan**  
I M A G I N G

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**PRESCRIPTION FORM**

Patient's Name \_\_\_\_\_ Dr.'s Name \_\_\_\_\_

**IMPLANTS**

Mark where implants will be approximately placed:

Upper Arch

Right Side        
 Left Side        1 2 3 3 5 6 7 8      9 10 11 12 13 14 15 16

Lower Arch

Right Side        
 Left Side        32 31 30 29 28 27 26 25      24 23 22 21 20 19 18 17

Instructions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**EXTRACTIONS**

Impacted Teeth

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

Wisdom Teeth

1      16      17      32

**TEMPO MANDIBULAR JOINT**

Instructions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**VOLUMETRIC STUDY FOR ORTHODONTIC EVALUATION**

Instructions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**EAR, NOSE AND PARANASAL SINUSES**

Instructions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Send images using the following:

- CD-ROM
- Prints on paper
- Via E-Mail
- Primary reconstruction CD-ROM
- Prints on films
- Radiologist interpretation

**Please bring this slip with you. Call first for an appointment.**