



"Dental & Maxillofacial Radiography"
www.mrsimaging.com

- Please call to schedule an appointment-

SANTA ANA

TIME MEDICAL PLAZA

720 N. Tustin Ave., #204, **SANTA ANA**, CA 92705-3606

Phone (714) 835-7260

FAX (714) 835-5808

PATIENT _____ AGE _____ APPT. DATE _____ TIME _____ FEE _____

EXAM STATUS:

☐ BEGINNING

☐ PROGRESS

☐ FINAL

2D ORTHODONTIC & SURGICAL EXAMS

____ Standard Exam: Dr. Rx on file

____ Orthodontic FMX Survey

Ceph, Tracing, Pan, 20 PA FMX series, Photos

____ Orthodontic Anterior/BW Survey

Ceph, Tracing, Pan, Anterior/Bitewing PA's, Photos

____ Orthodontic Limited Survey

Ceph, Tracing, Pan, Photos

____ Orthodontic Cephalometric Survey

Ceph, Tracing, Photos

2D CEPH/PAN X-RAYS (SINGLE FILMS)

☐ LATERAL CEPH ☐ TRACING _____

☐ PA or AP CEPH ☐ TRACING _____

☐ Panoramic

SPECIAL REQUESTS

GENERAL PROCEDURES

____ FMX (20 PA's)

____ Anterior PA's Max/Mand

____ Bitewings (4)

____ Occlusals: ____ Max ____ Mand

____ Carpal Index

____ Clinical Photographs

____ Duplicate Records

Digital Intraoral Scan by Itero

____ Invisalign ____ STL files

TOOTH SPECIFIC SITE MAP

MAXILLA

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

MANDIBLE

CONE BEAM VOLUMETRIC TOMOGRAPHY

(CBVT) digital 3-D oral & maxillofacial scan

____ TMJ/Closed and Open

____ IMPLANT (check site map) ____ Guide

____ Periapical IMPACTION (check site map)

____ AIRWAY

Receiving Format for CBVT Data

____ DICOM data/viewer disk or email

____ DATA Conversion

____ PRINTED Images

____ Radiologist Report (BeamReaders)

Record Request Format:

____ Prints ____ CD/DVD ____ EMAIL

*Disclaimer: All radiographic images are captured by licensed Technicians, and should be interpreted and reviewed by a licensed Practitioner.

REFERRED BY DR. _____

DATE _____

PLEASE BRING THIS Rx SLIP. CA State Law Requires Presentation Of This Written Rx At Time Of Appointment

MAP & INSTRUCTIONS ON BACK OF THIS Rx 5/25