



**RADIOGRAPHIC & PHOTOGRAPHIC PRECISION DENTAL**  
 www.cdental.com info@cdental.com  
**Jerome N. Peck, DLXT**

**San Rafael**  
 1050 Northgate Dr. Ste. 110  
 San Rafael, CA 94903  
 Tel: 415.472.1323 Fax: 415.472.1364

**San Francisco - Downtown**  
 450 Sutter St. Ste. 1542  
 San Francisco, CA 94108  
 Tel: 415.421.1389 Fax: 415.421.0146

**South San Francisco**  
 1135 Mission Rd. Ste. 201  
 South San Francisco, CA 94080  
 Tel: 650.589.4426 Fax: 650.589.1592

**Mountain View**  
 505 South Dr. Ste. 7  
 Mountain View, CA 94040  
 Tel: 650.965.1320 Fax: 650.428.0505

**San Mateo**  
 2006 Pioneer Ct.  
 San Mateo, CA 94403  
 Tel: 650.685.8097 Fax: 650.685.8099

**San Francisco - West Portal**  
 362 West Portal Avenue  
 San Francisco, CA 94127  
 Tel: 415.753.8701 Fax: 415.753.8703

**Menlo Park**  
 695 Oak Grove Ave. Ste. 330  
 Menlo Park, CA 94025  
 Tel: 650.323.0204 Fax: 650.329.0265

Patient: \_\_\_\_\_ DOB: \_\_\_\_\_ Referral Date: \_\_\_\_\_ Appointment Date: \_\_\_\_\_ Time: \_\_\_\_\_

GENERAL	TOMOGRAPHIC 3-D	ORTHODONTIC 2-D																																
1 <input type="checkbox"/> Panograph  2 <input type="checkbox"/> Panograph & Remaining Teeth  3 <input type="checkbox"/> Full Mouth Survey <input type="checkbox"/> 20 Films <input type="checkbox"/> VBWS <input type="checkbox"/> Grids <input type="checkbox"/> 27 Films <input type="checkbox"/> HBWS  4 <input type="checkbox"/> Posterior Bitewings <input type="checkbox"/> Horizontal <input type="checkbox"/> 4 Films <input type="checkbox"/> Grids <input type="checkbox"/> Vertical <input type="checkbox"/> 2 Films  5 <input type="checkbox"/> Vertical Bitewings All Around  6 <input type="checkbox"/> Paralleling Survey  7 <input type="checkbox"/> Occlusals <input type="checkbox"/> Mandible <input type="checkbox"/> Maxilla <input type="checkbox"/> Topographical  8 <input type="checkbox"/> Single Area <input type="checkbox"/> Grids	9 <input type="checkbox"/> NewTom Orthodontic Survey 10 <input type="checkbox"/> Limited NewTom Orthodontic Survey 11 <input type="checkbox"/> TMJ Survey <input type="checkbox"/> Open & Closed <input type="checkbox"/> Closed only <input type="checkbox"/> With splint <input type="checkbox"/> At rest (with bite registration) 12 <input type="checkbox"/> Implant Survey (indicate area below) <input type="checkbox"/> With stent <input type="checkbox"/> iDent <input type="checkbox"/> Simplant <input type="checkbox"/> Nobel Biocare (patient must have bite registration) 13 <input type="checkbox"/> Impaction Survey (indicate areas below) 14 <input type="checkbox"/> Pain Survey 15 <input type="checkbox"/> Sinus Survey 16 <input type="checkbox"/> OSA Survey (Airway) 17 <input type="checkbox"/> Custom Survey on file in office 18 <input type="checkbox"/> Radiologist Report to Dr. Danforth <input type="checkbox"/> Other _____	<input type="checkbox"/> Beginning <input type="checkbox"/> Progressive <input type="checkbox"/> Final  <input type="checkbox"/> Invisalign <input type="checkbox"/> Dolphin  19 <input type="checkbox"/> Orthodontic Survey Child 20 <input type="checkbox"/> Orthodontic Survey Adult 21 <input type="checkbox"/> Custom Orthodontic Survey (on file in office) 22 <input type="checkbox"/> Limited Orthodontic Survey 23 <input type="checkbox"/> Cephalometric <input type="checkbox"/> Lateral <input type="checkbox"/> AP <input type="checkbox"/> PA <input type="checkbox"/> Reverse Townes <input type="checkbox"/> Waters <input type="checkbox"/> 45 <input type="checkbox"/> 30 <input type="checkbox"/> 15 24 <input type="checkbox"/> Cephalometric Tracing <input type="checkbox"/> Steiner <input type="checkbox"/> Jarabak <input type="checkbox"/> Ricketts <input type="checkbox"/> Sassouni <input type="checkbox"/> Other _____ <input type="checkbox"/> Custom _____  25 <input type="checkbox"/> Hand/Wrist: AP, Left 26 <input type="checkbox"/> Photography																																
<b>Indicate Area(s):</b> <table style="width:100%; text-align:center; border-collapse: collapse;"> <tr> <td style="border-right: 1px solid black;">1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td> <td style="border-right: 1px solid black;">9</td><td>10</td><td>11</td><td>12</td><td>13</td><td>14</td><td>15</td><td>16</td> </tr> <tr> <td style="border-right: 1px solid black;">32</td><td>31</td><td>30</td><td>29</td><td>28</td><td>27</td><td>26</td><td>25</td> <td style="border-right: 1px solid black;">24</td><td>23</td><td>22</td><td>21</td><td>20</td><td>19</td><td>18</td><td>17</td> </tr> </table>		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	<b>Special Instructions:</b>
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																			

California State law requires that this written order be presented at time of appointment. Fees are payable at the time services are rendered. We accept VISA, MC, Cash & Check. Cancellations without 24 hour notice are subject to charges.

Referring Doctor: \_\_\_\_\_