



3909 Waring Road, Suite C, Oceanside, California 92056

760/630-0014 fax 760/630-0015

# REGENTS IMAGING

DATE EXAM REQUESTED: \_\_\_\_\_

Patient Name (Last) \_\_\_\_\_ (FIRST) \_\_\_\_\_ (MI) \_\_\_\_\_ Date Of Birth: \_\_\_\_\_

Phone (Home) \_\_\_\_\_ (WORK) \_\_\_\_\_ Social Security # \_\_\_\_\_

Referring Dentist : \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

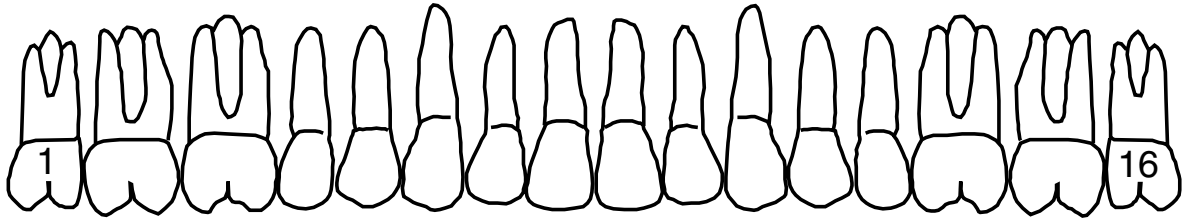
Appointment Date \_\_\_\_\_ Appointment Time \_\_\_\_\_

### CT Dental Implant Scan

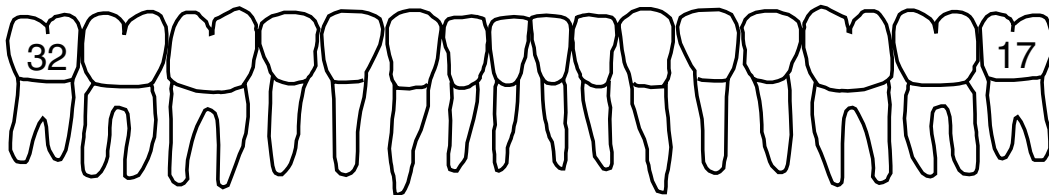
- Mandible     With Appliance
- Maxilla     With Editing
- Both     Without Editing

\_\_\_\_\_  
**Referring Physician Signature**

Please indicate any planned dental implants, bridges or metal in patient's mouth:



Patient's  
Right



Patient's  
Left

Clinical History: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Will Send CD Rom to Your Office