



CROALL RADIOGRAPHY, INC.
 5150 GRAVES AVENUE, BUILDING #8, SUITE D
 SAN JOSE, CA 95129
 TEL.: 408/446-9729 FAX: 408/446-9799
 BY APPOINTMENT

PATIENT _____ AGE _____

APPOINTMENT DATE _____ HOUR _____ FEE _____

This time is reserved exclusively for you. 24 hour notice is necessary for cancellation.

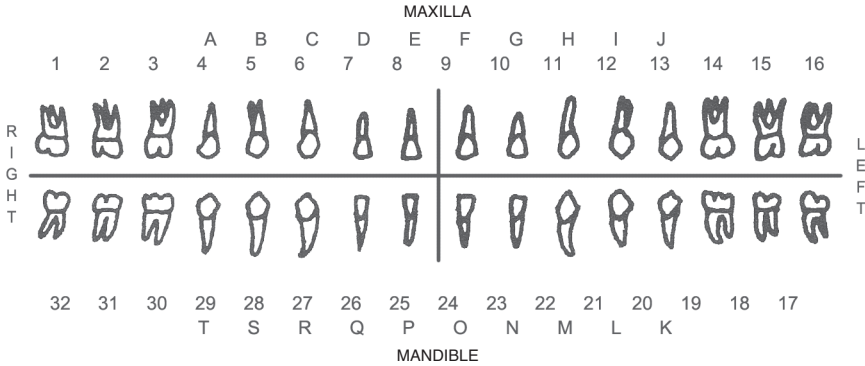
PLEASE NOTE

• Hours: Monday thru Thursday 9:00 am - 5:00 pm, Friday until Noon.

• Fees: Fees payable at time of service.



• Cancellations: \$25 fee will be added for less than 24 hour notice.

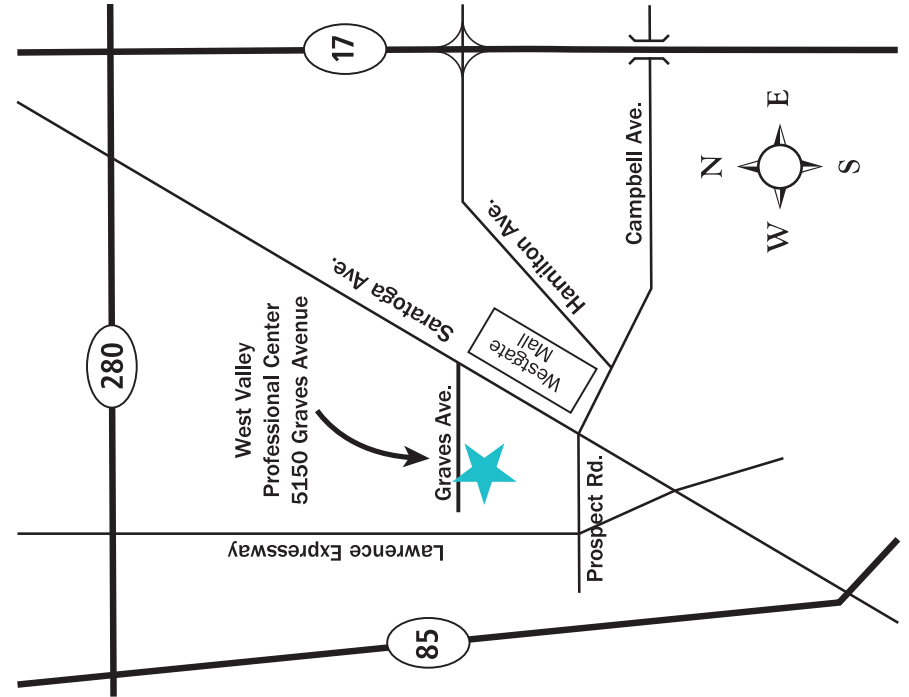


- 1. ORTHODONTIC SERIES
- 2. SUBMENTAL VERTEX
- 3. TMJ CONE BEAM CT SCAN
- 4. RADIOGRAPHIC REPORT
- 5. LATERAL CEPHALOMETRIC
- 6. CEPHALOMETRIC TRACING AND ANALYSIS
- 7. ANTERIOR CEPHALOMETRIC
- 8. PANORAMIC
- 9. DIAGNOSTIC PHOTOGRAPHS
- 10. POSTERIOR BITE-WINGS
- 11. OCCLUSALS MAXILLARY MANDIBULAR
- 12. CARPAL INDEX (WRIST)
- 13. SINGLE AREA (INDICATE ABOVE)
- 14. IMPLANT CONE BEAM CT SCAN
- 15. CONE BEAM CT SCAN (INDICATE AREA ABOVE)

INSTRUCTIONS: _____

REFERRED BY DOCTOR: _____

California State Law requires this written order to be presented at time of appointment.

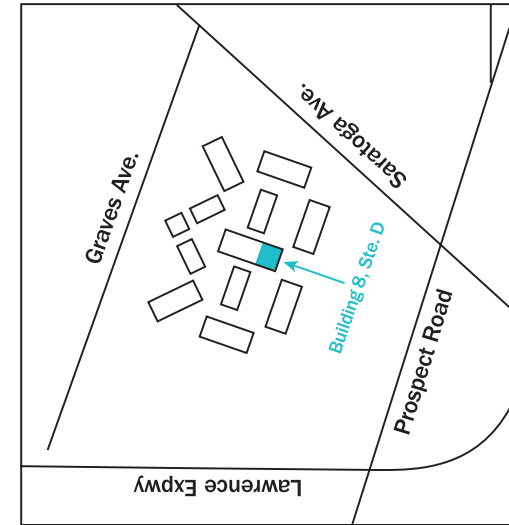


Parent/Guardian _____

Address _____

City _____ State _____ Zip _____

Telephone _____



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