Croall Radiography, Inc.
10353 Torre Avenue, Suite B
Cupertino, CA 95014
Tel: 408/996-3442 Fax: 408/996-3464

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.
  VISA MasterCard
- Cancellations: $25 fee will be added for less than 24 hour notice.

MAXILLA

			A	B	C	D	E	F	G	H	I	J			
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16

RIGHT — LEFT

32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
			T	S	R	Q	P	O	N	M	L	K			

MANDIBLE

- ☐ 1. ORTHODONTIC SERIES
- ☐ 2. SUBMENTAL VERTEX
- ☐ 3. LATERAL CEPHALOMETRIC
- ☐ 4. CEPHALOMETRIC TRACING AND ANALYSIS
- ☐ 5. ANTERIOR CEPHALOMETRIC
- ☐ 6. PANORAMIC
- ☐ 7. DIAGNOSTIC PHOTOGRAPHS
- ☐ 8. POSTERIOR BITE-WINGS
- ☐ 9. OCCLUSALS ☐ MAXILLARY ☐ MANDIBULAR
- ☐ 10. CARPAL INDEX (WRIST)
- ☐ 11. SINGLE AREA (INDICATE ABOVE)

INSTRUCTIONS: ______________________

REFERRED BY DOCTOR: ______________________

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

Lawrence Expw.
Miller Ave.
280
Stevens Creek Blvd.
TORRE PROFESSIONAL CENTER
10353 TORRE AVENUE
Torre
Pacifica Dr.
Bollinger Rd.
Prospect Rd.
De Anza Blvd.
85
N E S W

PARENT/GUARDIAN ______________________

ADDRESS ______________________

CITY ________ STATE ________ ZIP ________

TELEPHONE ______________________

N S
Blaney Ave.
Torre Ave.
Ste.B
Rodrigues Ave.
Pacifica Dr.
Bollinger Rd.
De Anza Blvd.

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