

CROALL RADIOGRAPHY, INC.



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

PATIENT _____ AGE _____

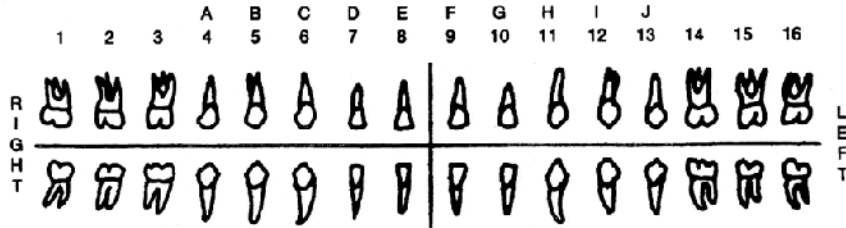
APPOINTMENT DATE _____ HOUR _____ FEE _____

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



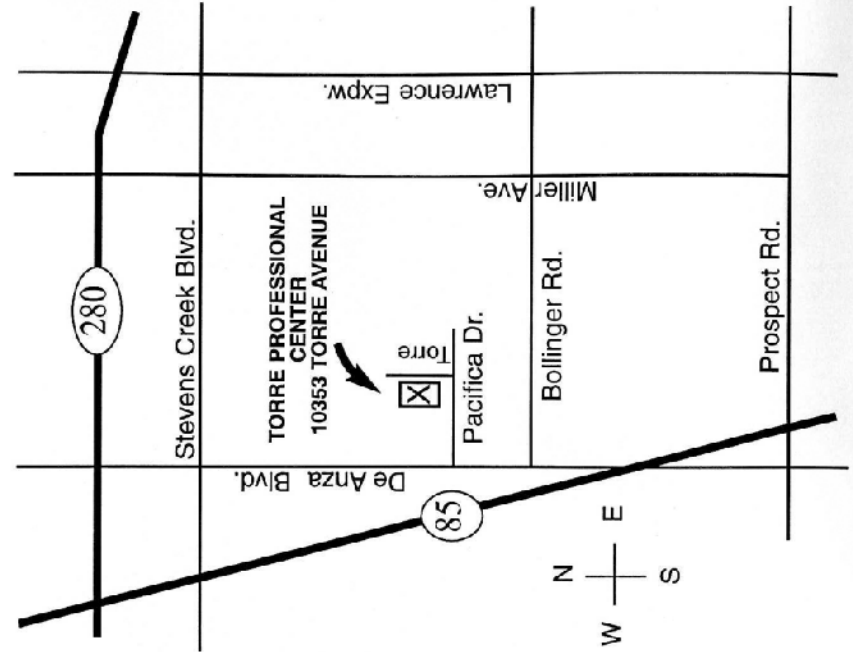
MANDIBLE

- 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.

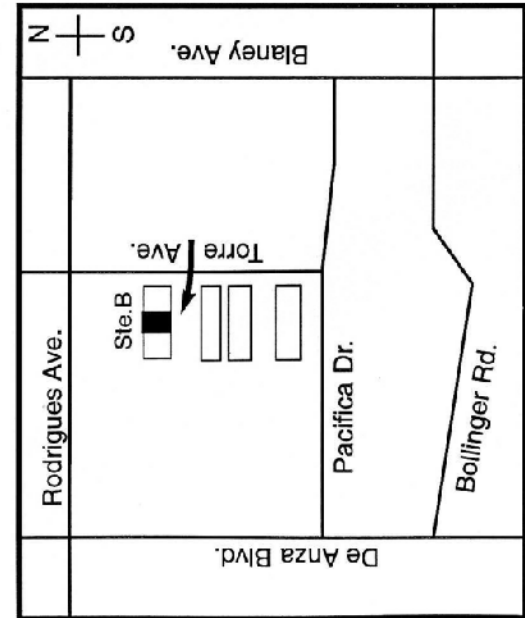


PARENT/GUARDIAN _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

TELEPHONE _____



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