6543 Montecito Blvd ● Santa Rosa, CA 95409 ● (707)791-7460
● www.GreenTreeOrthodontics.com ● info@GreenTreeOrthodontics.com

Date: ____

Patient's
Name:____

Patient's
Phone:____

Patient DOB: _________________________________

Referring
Doctor:_______________________________________

Email address of referring doctor:

____

Remarks:
____

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____

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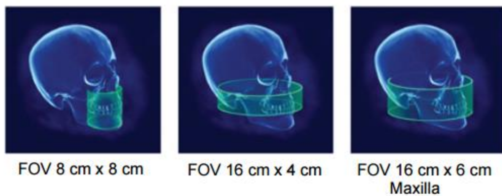
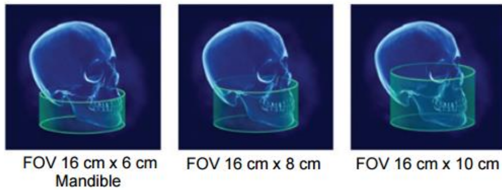
Please select Field of View (FOV):



FOV 8 cm x 8 cm | FOV 16 cm x 4 cm | FOV 16 cm x 6 cm Maxilla



FOV 16 cm x 6 cm Mandible | FOV 16 cm x 8 cm | FOV 16 cm x 10 cm

FOV 16 cm x 11 cm | FOV 16 cm x 13 cm | FOV 23 cm x 17 cm

Please select voxel size:

0.3mm or 0.4mm

Please select resolution:

Quick Scan + (lowest resolution)

Quick Scan

Standard

Enhanced (highest resolution)

Radiologist report needed? yes* or no

If yes, please specify area that you would like radiologist to evaluate: _________________________

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*additional fee