LUX

DENTAL

1631 DAVIE STREET, VANCOUVER BC,
V6G 1W1
T: 603 670 1256 F: 604 200 1398

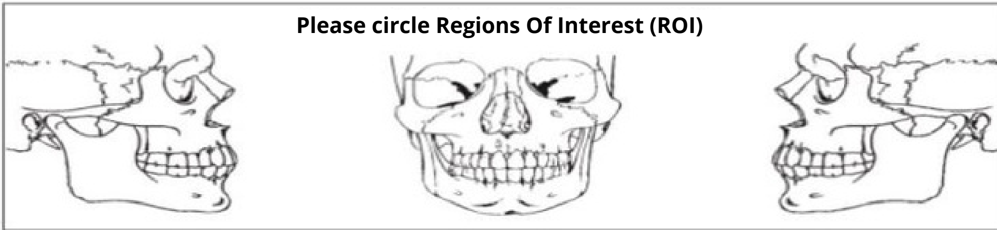
Patient's Name: ______________________ **Date of birth:** ______________ **Cell Phone:** ______________

Email: ______________________________ **Address:** ____

Insurance Company: __________________ **Policy:** __________________ **ID:** ______________________

Please circle area of concern

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8



Reason for scan & specific instructions or notes:

Area: ☐ Single jaw ☐ Both jaws ☐ Segment (please specify) :______________________________

Scan sent by: Email / CD

Dr. Name: ______________ **Clinic:** ______________

Dr. Signature: ______________ **Date:** ______________