Faculty of Dental Medicine and Oral Health Sciences | Faculté de médecine dentaire et des sciences de la santé orale

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PATIENT	REFERRING DENTIST
Name	Name
Date of Birth _____ ____F	Phone number
Phone number	Address
Email address	

Clinical Information
Indicate the area of interest
Right side: 11 12 13 14 15 16 17 21 22 23 24 25 26 27 / 41 42 43 44 45 46 47 32 33 34 35 36 37 — Left side: 28 / 38

REASON FOR IMAGING

Please check all that apply

3D Imaging (CBCT)
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