

CONE BEAM-COMPUTED TOMOGRAPHY (CB-CT) CONTROL

Patient informations : (capital letters)

Ms, Mr. Last name: First name:
 Birth date :

Your dentist :

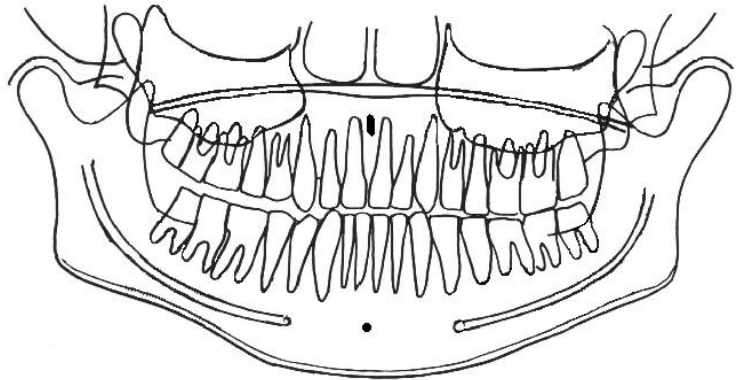
Name of your dentist:
 Address: Post code: City:

Region(s) to be radiographed:

.....

Remark :

.....



Please, mark the region(s) to be radiographed.

Date: Signature of dentist and stamp:

- This form, filled by your dentist, will be given to the receptionist of the Ardentis clinic in Lausanne.
- Please take any pertinent radiographs given by your dentist with you.
- At the end of the control, a CD-ROM will be recorded. Please transmit it to your dentist. A copy of data will be kept saved on our server.
- The cost of the radiographical examination will be paid at the end of the appointment.
- For the patients of Ardentis: Radiographs will be transmitted through our internal network and recorded in your personal computerized file.

Ardentis Lausanne
Voie du chariot 6
1003 Lausanne

For an appointment
Tel. 058 234 00 20

More informations :
www.ardentis.ch

