DENTAL TECHNOLOGY CENTER
OF HAWAII

1314 S. King St., Suite 724 Honolulu, Hi 96814
O: 808.291.2254 E: dtcofhawaii@outlook.com

TODAY'S DATE: _____
Appointment Date/Time

PATIENT NAME: _____
DOB

REFERED BY: _____
PHONE

EXTRAORAL STUDIES

☐ PANORAMIC ☐ EXTRAORAL BITEWINGS

☐ PA CEPHALOMETRIC ☐ LATERAL CEPHALOMETRIC

CONE BEAM VOLUMETRIC SCAN

☐ IMPLANT ☐ TOOTH #: _____

☐ MAXILLA ☐ MANDIBLE ☐ BOTH

☐ ENDODONTICS ☐ TOOTH #: _____

☐ FRACTURE ☐ MISSED CANAL

☐ PATHOLOGY/REPORT ☐ SINUS EVALUATION ☐ IMPACTED TOOTH ☐ AIRWAY ASEESSMENT

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

SPECIAL INSTRUCTIONS / COMMENTS: _____

_____

_____

_____

Please arrive 10 minutes prior to your scheduled appointment, and remember to bring your medical card with you.
Complimentary 30 minute parking validation.

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