ardentis
CLINIQUE DENTAIRE
VEVEY

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 :

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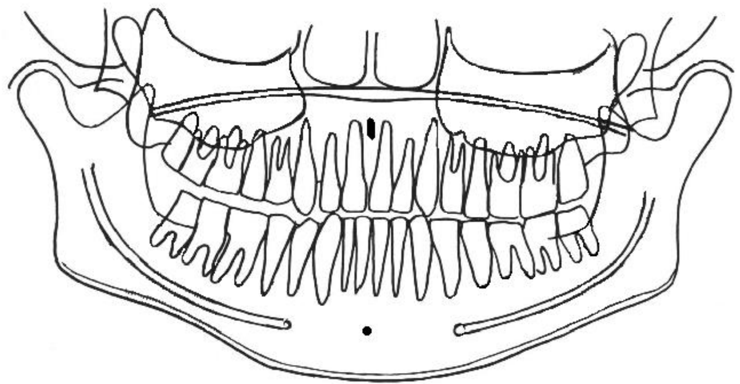

Please, mark the region(s) to be radiographed.

Date: …………………………… *Signature of dentist and stamp:* ………………………………………

- ***This form, filled by your dentist, will be given to the receptionnist 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 Vevey
Rue du Collège 3
1800 Vevey

For an appointement
***Tel.* 058 234 00 10**

More informations :
www.ardentis.ch