CHAPEL ROAD ORTHODONTICS

Confidence in your smile

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Kent DA7 4HW

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Email: info@chapelroad.co.uk
www.chapelroad.co.uk

From: (*Referring Dentist's Stamp*)

Date: / /

X-Ray Request

Patient's Name (Mr/Mrs/Miss) .....

D.O.B ..... / ..... / .....

Address: .....

.....

..... Post Code .....

Contact Number:

Home: ..... Mobile: .....

Please take the following radiographs:

☐ Panoral ☐ TMJ ☐ Ceph

.....

Signature of referring dentist

Patient Charges: Panoral £38.00 / TMJ £38.00 / Ceph £55.00

Please tick if you require further supplies of this form ☐

International Member American Association of Orthodontists

Member of the BOS British Orthodontic Society