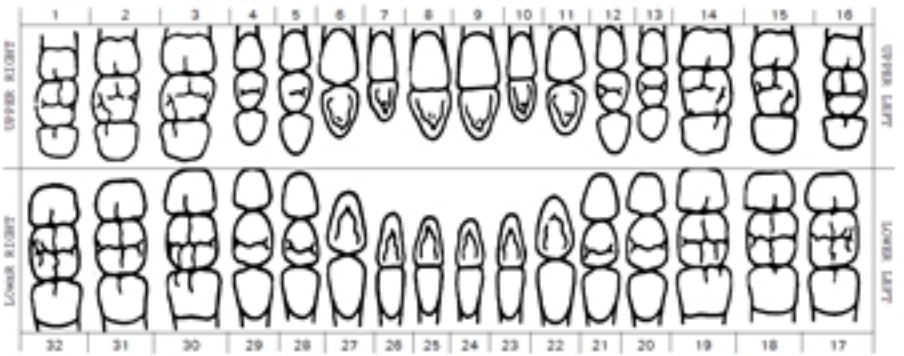
Patient Name:_____

Exam Regarding: _____

_____

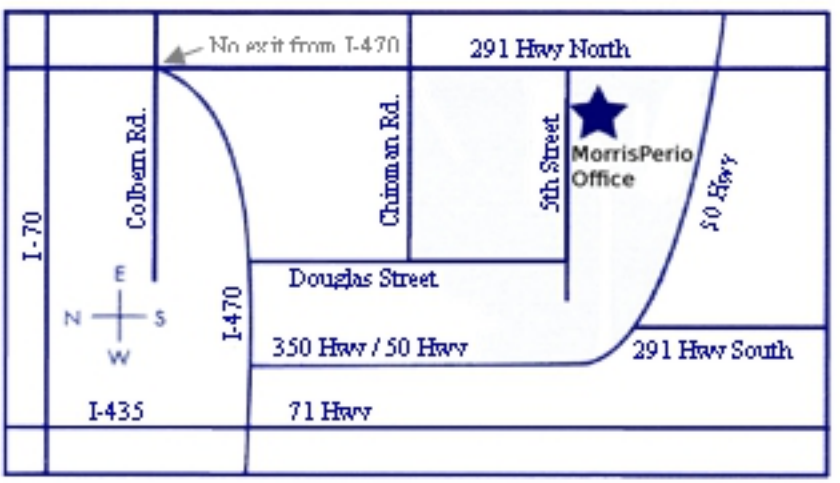
_____

Specific Problem Area



Radiographs ☐ Mailed
☐ E-mailed
☐ May be taken in your office
☐ Sent With Patient

☐ We have scheduled an appointment with your office on _____ at _____ AM/PM



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