Radiographic Assessment

Form 9

Surname ____________________

Forename ____________________

Age [ ][ ]   Sex [ ]

For office use

CHI Number D D M M Y Y [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

Examination Date

Day [ ][ ]   Month [ ][ ]   Year [ ][ ][ ][ ]

Type of film(s)

Bitewings	Horizontal	R	L	*Periapical*
	Vertical	R	L	
Occlusal	Upper	Lower		
Extra-oral	OPG	Lateral Ceph	*Other*	

Quality of films taken

Radiation Dose / Setting

Clinical indication for taking film(s), and suspected diagnosis

Radiographic Report

Clinical examination undertaken by:

Date

Films authorised by:

Date

Films taken by:

Date

Signature of Practitioner ____________________ **Date** ____________________