



Pacijent: _____

Lekar/ordinacija: _____

Datum: _____

Intraoralno snimanje

Retroalveolarni snimak:

8	7	6	5	4	3	2	1		1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1		1	2	3	4	5	6	7	8

Retrokoronalni snimak:

8	7	6	5	4	3	2	1		1	2	3	4	5	6	7	8
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☐ Film

☐ CD

☐ Email

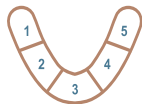
Ekstraoralno snimanje

Ortopan:

☐ Odrasli

☐ Deca

☐ Sekcioni:
zaokružiti regiju



Zagrizni snimak („Bitewing“):

☐ Obe vilice

☐ Desna

☐ Leva

Maksilarni sinusi

☐ Sinusi

TMZ:

☐ Zatvoren

☐ Otvoren

☐ Oba

☐ Desni

☐ Levi

☐ Oba

☐ Film

☐ CD

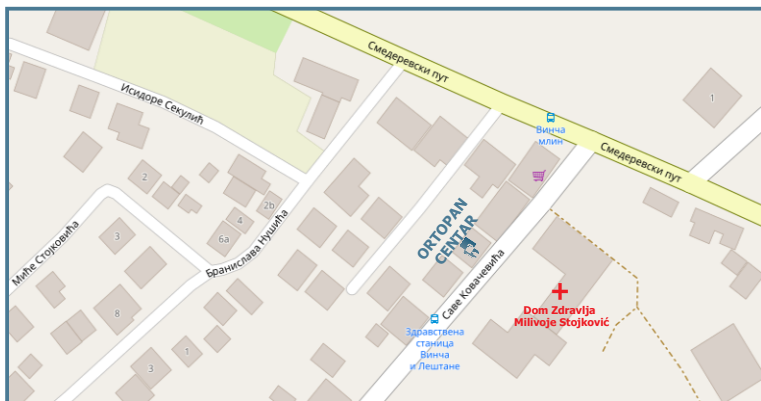
☐ Email



Ortopan Centar
Leštane

**UPUT ZA
SNIMANJE**

KONTAKT



Radno vreme: 10 - 20č



Ortopan Centar
Leštane

Save Kovačevića 2r, 1.Sprat
Leštane - Beograd, Srbija
Mob. 065.431.2222
ortopanleštane@gmail.com
www.ortopanleštane.rs