CONE-BEAM COMPUTED TOMOGRAPHY (CBCT) REQUEST FORM

FOR EXTERNAL REFERRING PRACTITIONERS

PATIENT INFORMATION

Name: _____ Date of Birth: _____ Gender: _____

Mailing Address: _____

Phone (Cell/Home/Work): _____

REFERRING DENTIST / DENTAL SPECIALIST INFORMATION

Name: _____ Dental License State & Dental License Number: _____

Phone: _____ Fax: _____ Email: _____

Signature: _____ Date of Request & Signature: _____

STUDY INFORMATION

Indication(s), Significant Clinical Findings, and Relevant Dental History: _____

_____

_____

Relevant Medical and/or Medication(s) History: _____

_____

Special Considerations or Additional Comments: _____

_____

Area(s) of Interest to be Imaged:

- ☐ Limited Field-of-View (FOV) Specific Site(s): _____
- ☐ Maxilla Only
- ☐ Mandible Only
- ☐ Maxilla & Mandible
- ☐ Maxillofacial Region with Skull

Additional Scan Options:

- ☐ Separate Jaws
- ☐ Separate Lips and Cheeks
- ☐ Radiographic Stent ☐ Scan Radiographic Stent Separately
- ☐ Temporomandibular Joint (TMJ) Evaluation (Studies in Closed & Open Jaw Positions)

BILLING INFORMATION

Please note that the patient is responsible for payment at the time of service.