



**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 CLINICIAN INFORMATION**

Name: \_\_\_\_\_ License State & 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.