CRANIOFACIAL IMAGING

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Patient referral for: CONE BEAM 3D SCAN

Please bring this written order with you on the day of your appointment

PATIENT_____ DOB_____

Appointment Date_____ Time_____

REFERRING DOCTOR_____ Phone_____

Address _____ E-Mail_____

Fee due at time of service $_____

1. CIRCLE ALL THAT APPLY Maxilla Mandible

Implant Impaction Supernumerary Sinus Cyst

2. CIRCLE REGION OF INTEREST BELOW

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

3. SPECIAL NOTES

_____

_____

4. RADIOLOGIST'S REPORT? YES _____ NO_____

5. FORMAT PREFERENCE - CIRCLE CHOICE(S)

VIEWER CD DICOM PRINTS 3rd PARTY