LEGACY DENTAL

CBCT Referral & Requisition

DATE: _____/_____/_____
Day Month Year

Patient Information

Last Name: _____
First Name: _____
Address: _____
City: _____
Postal Code: _____
Date of Birth: _____

Home Phone: _____
Cell Phone: _____
Other Phone: _____
Email: _____
Prov. Health Card #: _____
Gender: M___ F___

Referring Doctor

Clinic Name: _____
Address: _____
Phone: _____
Fax: _____

Dr. _____

_____
Referring Dr. Signature

Indications for Scan

___Implants ---Scan with Stent
___Wisdom Teeth
___Painful/Cracked/Troublesome Teeth
___Impacted/Delayed/Extra/Malpositioned Teeth
___Salivary Gland
___Disease/Syndrome/Tumor/TMJ
___Facial/Muscle Pain/Paralysis/Abnormal Sensation
___Other _____

CBCT ACQUISITION ONLY

Scan Size (field of view)

___07011 5x5 (sextant) - $150
___07012 5x8 (one arch) - $150
___07013 8x8 (two arches) - $150

This is for CBCT acquisition only. The ordering doctor will be responsible for interpretation and/or sending to an oral radiologist for interpretation. We will NOT direct bill insurance companies for this service. The CBCT will be provided on a DVD-R with basic viewing software.

Please indicate tooth number(s) or area

_____
_____
_____
_____

For Office Use Only

Form Received: _____/_____/_____
Patient Contacted: _____/_____/_____
Appointment Date:_____/_____/_____

NOTES:

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