CONE BEAM CT SCAN REQUEST FORM

(FOR REFERRING PRACTITIONERS OUTSIDE OF OSU COLLEGE OF DENTISTRY)

PATIENT INFORMATION Date of Request: _____

Patient Name: _____DOB: _____

Mailing Address_____

Phone: (Home) _____ Phone: (Cell/Work) _____

REFERRING CLINICIAN INFORMATION

Name: _____ License State & No.: _____

Phone: _____Fax: _____email: _____

Clinical Working Diagnosis:_____

Relevant Medical and Dental History:_____

_____

Signature _____ **Date:** _____

Region to be Scanned :

☐ Small FOV: Specific Sites _____

☐ Maxilla ☐ Mandible ☐ Both Jaws ☐ Full Head

☐ TMJ: ☐ Open Mouth ☐ Closed Mouth

Scan Options:

☐ Radiographic Stent ☐ Separate Jaws

☐ Separate Lip & Cheek

BILLING INFORMATION

RESPONSIBLE PARTY: ☐ Referring Practitioner ☐ Patient

ADDITIONAL COMMENTS _____

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