



**CONVENTIONAL RADIOGRAPH 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: \_\_\_\_\_

\_\_\_\_\_

Please select **all** extraoral imaging modalities indicated:

- Panoramic Radiograph
- Lateral Cephalometric Radiograph
- Posteroanterior (PA) Cephalometric Radiograph

Please select **all** intraoral imaging modalities indicated:

- Full Mouth Series
- Bitewing Radiograph(s) as Specified: \_\_\_\_\_

\_\_\_\_\_

- Periapical Radiograph(s) as Specified: \_\_\_\_\_

\_\_\_\_\_

**BILLING INFORMATION**

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