CBCT REFERRAL FORM

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TALL PINES DENTAL
DR BRUCE MOSS

REFERRING CLINICIAN

NAME: _____
PHONE: _____
EMAIL: _____
ADDITIONAL RESULTS SENT TO: _____

PATIENT NAME: _____
PHONE: _____
EMAIL: _____
DATE of BIRTH: (M/D/YY) _____

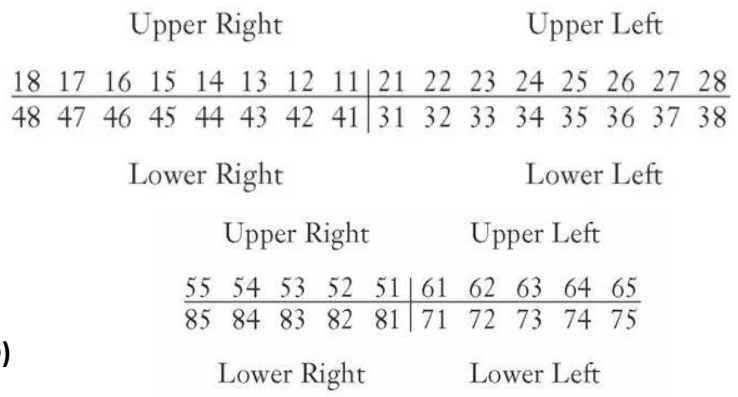
PRICING

_____ SM 5x5 $325
_____ 1 ARCH 8x5 $375 UPPER ___ LOWER ___
_____ 2 ARCH 8x8 $425

REPORT URGENCY: (PLEASE CHECK ONE)

24 hrs _____ +$125
1-2 days _____ +$100
3-6 days _____ +$75
7-12 days _____ +$50
12-17 days_____ +$25
6 weeks _____ No extra fee

REGION OF INTEREST: (circle tooth area)



RELEVANT CLINICAL DETAILS & HISTORY (REQUIRED)

_____
_____
_____

INDICATIONS OF SCAN (PLEASE CHECK ONE):

IMPLANT ____ WISDOM TEETH ____ SALIVARY GLAND ____
DISEASE/SYNDROME/TUMOUR/TMJ _____
FACIAL/MUSCLE PAIN/PARALYSIS/ABNORMAL SENSATION ____
PAINFUL/CRACKED/TROUBLESOME TEETH (ENDO) ____ OTHER ____

REFERRAL DETAILS:

_____
_____
_____