# 3D Cone Beam CT Scan Referral Form

Patient Name: _____ Date of Birth:_____

Telephone: _____ Appt. Date: _____

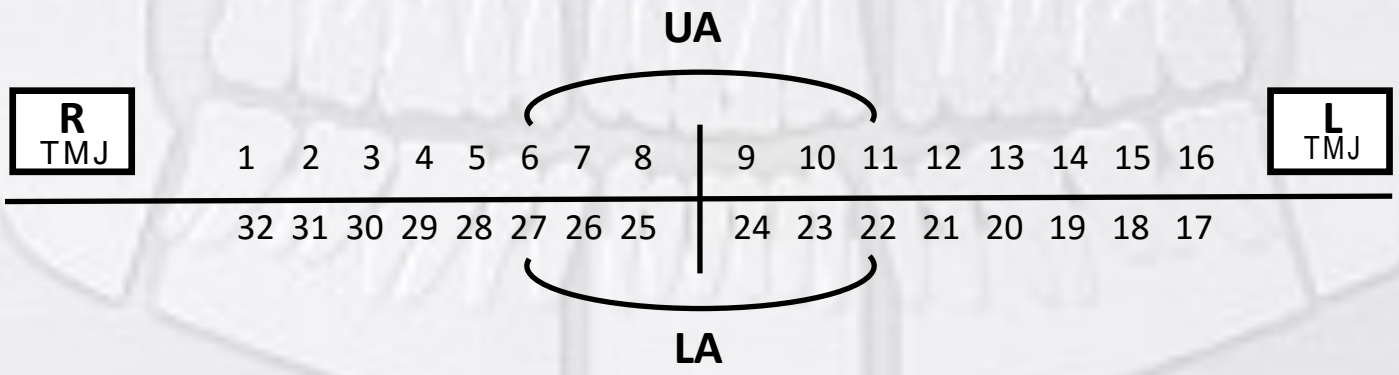
Referring Doctor: _____ License # _____

*Acquire 3D images at 76 microns/0.076 mm voxel size, 1:1 "true-to-life" scale*

**1) Please Check the purpose for the Scan:** ___Surgery ___Implantology ___TMJ Exam ___Orthodontics ___Endodontics ___Fracture ___Pathology

**2) Please Check the Type of the Scan:**

☐ 3D Focused-field scan size 50X37mm: $99 *(please check the box or up to 6 adjacent teeth):*




Area of Interest : Mandible: _____ Maxilla: _____

☐ 3D Extended Field-of-View: $199 *(Available extended field-of-view module combines up to 3 volumes for full arch reconstruction) :*

**___Full Upper Jaw (Stitched)** **___Full Lower Jaw (Stitched)**

☐ 2D Diagnostics: $99 each:

___ Standard Panoramic ___Child Panoramic
___ Segmented Panoramic ___Lateral TMJ ( X 4 views)
___Maxillary Sinus

___ Cephalometric: ◯ Lateral full skull ◯ Frontal PA ◯ Frontal AP ◯ Submento vertex ◯ Carpus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**The Dental Emergency Room does not provide interpretation of these scans.**