

DENTAL CT SCAN REFERRAL FORM



Note to Patient: Please bring this referral form with you. Payment is due when services are rendered.

Advanced Dental is not responsible for image interpretation, reading of findings. The diagnosis and treatment planning is the responsibility of the referring doctor.

ADVANCED DENTAL
Phone: (718) 292-8988
237 Willis Avenue, Bronx, NY 10454
Fax: (917) 792-7979

Date: _____ / _____ / _____

Patient Name: _____ D.O.B _____ / _____ / _____

Ref. Doctor Name: _____ Doctor Phone: _____

Address: _____

CASE TYPE select one

- | | | |
|--|---|--------------------------------|
| <input type="checkbox"/> IMPLANT | <input type="checkbox"/> PATHOLOGY | <input type="checkbox"/> ORTHO |
| <input type="checkbox"/> IMPACTION | <input type="checkbox"/> SINUS/ AIRWAYS | <input type="checkbox"/> OTHER |
| <input type="checkbox"/> SUPERNUMERARY | <input type="checkbox"/> TMJ STUDY | _____ |

- Radiology Report Delivery** Paper E-mail _____
- Return to office w/CD Send w/Patient

Special Instructions:

REGION OF INTEREST

