DENTAL X-RAY REQUEST

VDIG
Victorian Dental Imaging Group

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[ ]	BENDIGO:	86 Baxter Street	Ph: 5442 5100	E: bendigo@vdig.com.au

Patient Details

Name_____ DOB _____

Address_____ Contact Phone_____

Examination Requested

Standard X-rays [ ] OPG [ ] Lat Ceph [ ] PA Ceph [ ] TMJs [ ] Bone Age [ ] Intra-Oral/s

Cone-Beam CT Scan [ ] Maxillary [ ] Mandibular [ ] Both Arches [ ] TMJ Study [ ] ENT [ ] Other _____

Clinical Information

Right	18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28 Left
	48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38

Please select Area of Interest

Standard X-rays [ ] Examine Dentition [ ] 3rd Molars [ ] Bone Pathology [ ] Perio Status

Cone Beam CT [ ] Implant Study [ ] Impaction [ ] IDC localisation [ ] TMD [ ] Airway Study

Clinical Notes / Special Instructions

Image / Results Delivery

[ ] Email [ ] CD [ ] Cloud Transfer [ ] Paper [ ] X-ray Film **[ ] DICOM Data ONLY** **[ ] DICOM data WITH Viewer**

Referring Doctor

* Name_____ * Provider No _____

* Signature on Printout _____ * Date _____

** Required by Health Insurance Act Legislation*