DENTAL X-RAY REQUEST

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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

***For CBCT Scans:* Clinical notes assist with the selection of optimal scan parameters**

Image / Results Delivery

[ ] Email [ ] CD [ ] Cloud Transfer [ ] Paper **[ ] DICOM Data ONLY** **[ ] DICOM data WITH VIEWER**

Referring Doctor

* Name____ * Provider No _________________________

* Signature on Printout ____________________________ * Date ______________________________

** Required by Health Insurance Act Legislation*