Referral Form

3Dental · Mobile Dental Imaging

CBCT • Panoramic • Cephalometric • Intraoral Scan
Clinical Photography

Patient Information

Name (Print): _____ D.O.B.: _____

Address: _____ Email: _____

Phone: _____ Fax: _____

Referring Dentist/Clinic Information

Name (Print): _____ ○ Email: _____

Phone: _____ ○ Date: _____

Email: _____

Requested Examinations

- ☐ CBCT - 3D Tomography
- ☐ Panoramic Radiography
- ☐ Cephalometric Radiography
- ☐ Intraoral Scan
- ☐ Intraoral Radiograph; Periapical & BW
- ☐ Clinical Photography

○ Maxilla ○ Mandible

○ Implant Area #: _____

☐ Other: _____

Region of Interest (CBCT)

Indicate teeth or area of interest for measurement

- ☐ Maxilla
- ☐ Mandibula
- ☐ TMJ

1	2	3	4	5	5	7	8	9	10	11	12	13	14	15	16	17	18
32	31	30	29	28	29	27	25	24	23	22	21	22	20	19	19	18	17

- ☐ Specific Tooth #: _____
- ☐ Intraoral Scan _____
- ☐ Scanner Intraott: _____
- ☐ Implant Area
- ☐ Third Molars
- ☐ Endodontic
- ☐ Orthodontic Evaluation
- ☐ Maxillary Sinus: _____
- ☐ Endodontic Assessment: _____

Notes / Objective of Examination

☐ Send to the dentist ☐ Send to the patient ☐ Both _____

Email for delivery: _____

- Radiation exposure is minimal and within dental safety standards.
- Please bring ID to the appointment.
- Pregnant patients must inform the staff before imaging.

Dentist Signature:

_____

3Dental™
Mobile Dental Imaging

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