586-247-3500

Referral Form – Dental CT Scan

Patient Name: _____ Date:_____

Referring Doctor: _____ Office Phone: _____

3D Select Volume

- Full Dentition
- Tooth # ____
- Maxillary arch or Mandibular arch (please circle one or both)
- UR, UL, LL, LR quadrant (please circle one or more)
- Left TMJ or Right TMJ (please circle)
- Other: _____

2D Select Area

- Posterior Extraoral Bitewings
- Panoramic
- Both TMJ
- Other: _____

Email: _____