CBCT Referral Form

Village Dental House

REFERRING DOCTOR

PATIENT NAME

DATE OF BIRTH

PHONE

EMAIL

Reason for referral (select one)

- ◯ IMPLANT PLANNING
- ◯ IMPACTED 3RD MOLARS
- ◯ PATHOLOGY
- ◯ SINUS EVALUATION
- ◯ BONE GRAFTING
- ◯ ENDODONTICS
- ◯ AIRWAY
- ◯ ORTHODONTICS
- ◯ OTHER

ADDITIONAL INFORMATION

Scan size (select one)

- ◯ SMALL (5X5), $80
  Local diagnostics
- ◯ MEDIUM (6X9), $155
  Complete lower OR upper jaw
- ◯ LARGE (9X11), $180
  Entire dentition as well as some of maxillary sinus
  ***** Recommended for implant treatment planning *****

*****Do you wish to have your scan read by an oral radiologist? *****

Additional fee: $120

Please note: The responsibility of reading the scan is the referring dei
unless the scan is read by an oral radiologist.

◯ YES ◯ NO

* all scans will be available for download or usb key

Please email or mail this document to:

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