DENTAL IMAGING REFERRAL FORM

REFERRING DENTIST INFORMATION

Full Name: …….. Date Referred: ……..……...
Address: ……..……..……
Telephone: …… E-mail: ……..……..

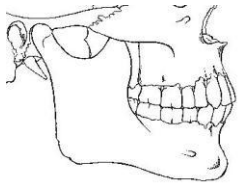
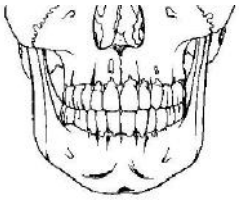
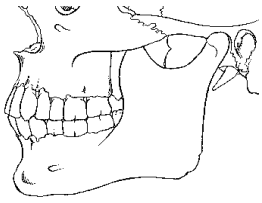
PATIENT INFORMATION

Patient's Name: …….. Date of Birth: ……..……..……..
Patient's Address: ……..……..……..
Home Tel: …… Mobile Tel: ……..……
(Check all that apply)

REASON FOR REFERRAL:
____ TMJ Assessment ____ Sinus Assessment ____ Airway Assessment
____ Endodontic Assessment ____ Implant Assessment ____ Implant Surgical Placement Only
____ Implant Surgical Placement & Restoration ____ Implant Problems & Diagnosis
____ Augmentation & Surgical Placement ____ Entire Maxillofacial Region ____ Orthodontic
____ Oral Pathology ____ Impaction Other: _____

____Cone Beam CT ____Digital Panoramic ____ Cephalometric

Region(s) of Interest:
……
……
Circle Area:

FORMAT DATA DELIVERY OPTIONS FOR SCAN:

___ DICOM CD
___ E-MAIL
___ PRINTS
___ DUPLICATE CD NEEDED

Other: ……..……..…..
PAYMENT: ____ Referrer ____ Patient

Please send by FAX to 856-428-7644 or SCAN and EMAIL, RE: Patient Referrals to:
cherryhilldentalexcellence@gmail.com

ONCE COMPLETED HAVE PATIENT CALL TO SCHEDULE AN APPOINTMENT