CONVENTIONAL RADIOGRAPH REQUEST FORM

FOR EXTERNAL REFERRING PRACTITIONERS

PATIENT INFORMATION

Name: _____ Date of Birth: _____ Gender: _____

Mailing Address: _____

Phone (Cell/Home/Work): _____

REFERRING CLINICIAN INFORMATION

Name: _____ License State & Number: _____

Phone: _____ Fax: _____ Email: _____

Signature: _____ Date of Request & Signature: _____

STUDY INFORMATION

Indication(s), Significant Clinical Findings, and Relevant Dental History: _____

_____

_____

Relevant Medical and/or Medication(s) History: _____

_____

Special Considerations or Additional Comments: _____

_____

Please select **all** extraoral imaging modalities indicated:

- ☐ Panoramic Radiograph
- ☐ Lateral Cephalometric Radiograph
- ☐ Posteroanterior (PA) Cephalometric Radiograph

Please select **all** intraoral imaging modalities indicated:

- ☐ Full Mouth Series
- ☐ Bitewing Radiograph(s) as Specified: _____

  _____
- ☐ Periapical Radiograph(s) as Specified: _____

  _____

BILLING INFORMATION

Please note that the patient is responsible for payment at the time of service.