CONE BEAM CT IMAGING REQUEST ORDER

TO: ***University of Louisville Oral and Maxillofacial Radiology Faculty Private Practice***
Uof L School of Dentistry, Suite 149, 501 South Preston St. Louisville, KY USA 40202

FAX ORDER TO: **(502) 852-7595** **CALL FOR APPOINTMENTS: (502) 852-1243**

FROM: Dr. ______________________ **FAX:** ______________________

______________________ **TEL:** ______________________

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PATIENT DETAILS (MUST BE COMPLETED)

Patient Name: ______________________ DOB: ____/____/____

Home Address: ______________________

Phone: (Work): ______________________ Phone: (home/cell): ______________________

REFERRING PRACTICTIONER

E-mail: ______________________ License #: ______________________

Relevant Clinical / Dental History: ______________________

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Signature: ______________________ Date: ____/____/ 20____

SERVICES REQUESTED

IMPLANT: **Arch:** ❑ Maxilla ❑ Mandible ❑ Both

Format: ❑ Entire arch(s) ❑ Specific Region: ______________________

Simplant: ❑ Custom / Basic Maxilla ❑ Custom / Basic Mandible ❑ Custom / Basic quadrant

THIRD MOLAR: ❑ Maxilla ❑ Mandible ❑ Both

TMJ: ❑ Closed only ❑ Open / Closed ❑ Closed with splint in

PATHOLOGY: ❑ Maxilla ❑ Mandible ❑ Both

Location / Working Dx: ______________________

TOOTH IMPACTION: ❑ Maxilla ❑ Mandible ❑ 3D Movie ❑ IAC Tracing

BILLING INFORMATION (We are unable to accept medical and dental insurance)

RESPONSIBLE PARTY: ❑ Patient ❑ Bill direct to referring practitioner

PAYMENT: ❑ Passport / Medicaid ❑ Credit/Card (Visa/Mastercard ONLY) ❑ Cash / Check

DELIVERY INFORMATION

DELIVERY:
❑ Hardcopy report/selected images ❑ Fax report/send images
❑ E-mail report/images as PDF ❑ CD – iCAT Vision viewing software
❑ DICOM data ❑ CD – KODAK viewing software (implant templates available)

COMMENTS