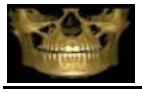
Miami CBCT

Digital Radiology Center for DENTISTS

9301 SW 56 ST Suite E **(305) 989-5577**
Miami, FL 33165 **Fax: (305) 595-4927**

Image Request Report

Image Mode: CBCT_____ Pano_____Ceph_____ **Requested by Dr.** _____
Patient Name: _____Gender____ Age____ License # _____
Patient Phone #_____ **Doctor's Phone#**_____
Do we contact Pt. for appointment: Y_____ N_____ **Doctor's E-mail** _____
Preferred Delivery Method: USB_____ DVD _____ Dropbox _____
Payment from: Patient _____ Dentist _____



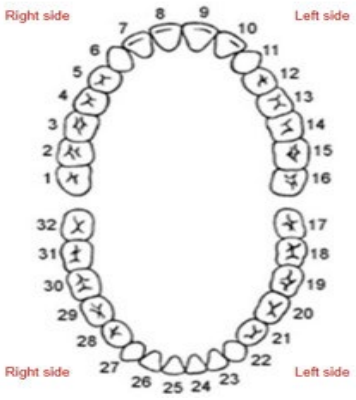
CBCT:

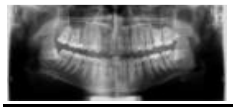
Field of View (FOV): 5x5___ (Small OK for 1-2 teeth) Tooth#____ 12x9____ (Medium) 15x15____ (Large)

Vertical Position: Mn____MX____Occl____TMJ____
Horizontal Position: Right ____ Center ____ Left ____
Metal Artifact Reduction: Skip ____ Apply ____
Radiologist Report: Yes_____ No _____(if yes please fill out below)

Study Purpose (Chose One)	Additional Notes
___Airway Evaluation	_____
___General Review	_____
___Impaction/Localization	_____
___Implants	_____
___Orthodontic Eval	_____
___Pathology	_____
___Sinus Evaluation	
___TMD Orofacial Pain	

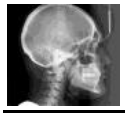
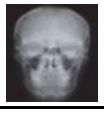
Select Region of Interest for Small F.O.V.





Panoramic:

Panoramic Examination: Standard ____ Right ____ Front ____ Left ____
Extraoral BWs ___ Bitewing Right___ Bitewing Left___ Bitewing Incisor___

Cephalometric:

Ceph Exam: Full Lateral___Lateral___ PA___ SMV___ Waters View___ Carpus___