Miami CBCT

Digital Radiology Center for DENTISTS

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

Image Request Report

Image Mode: CBCT_____ Pano _____ Ceph _____

Patient Name: _____

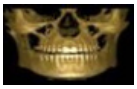
Gender: ___ Age: _____

Patient Phone #: _____

Delivery Method: USB _____ **DISC** _____ **Dropbox** _____
Payment from: Patient _____ **Dentist** _____

Requested by Dr. _____
License # _____
Doctor's Phone# _____
Doctor's Email _____

Do we contact Pt. for appointment: Y____ N____



CBCT: Field of View (FOV):

5x5 ___(Small OK for 1-2 teeth) Tooth#_____ 8x8 _____ Tooth# ____ 12x9 ____(Medium) 15x15____ (Large)
Vertical Position: Mn____MX ____Occl____TMJ ____
Horizontal Position : Right_____ Center _____ Left _____
Metal Artifact Reduction: Skip ____ Apply ____

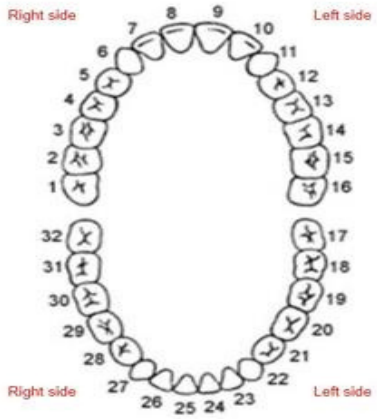
Radiologist Report is Recommended: Yes_____ No_____ (if yes please fill out below)
***Radiologist report is recommended for small FOV, but will be included for medium and large FOV.**

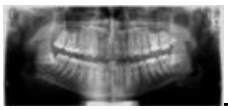
Study Purpose (Choose Applicable)

___ Airway Evaluation
___ General Review
___ Impaction/Localization
___ Implants
___ Orthodontic Eval
___ Pathology
___ Sinus Evaluation
___ TMD Orofacial Pain

Additional Notes:
_____
_____
_____
_____
_____
_____

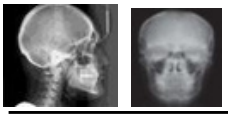
Select Region of Interest for Small F.O.V.





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___