michigan avenue
DENTISTRY

DIGITAL IMAGING REQUEST

PATIENT INFORMATION

NAME: ____________________

DOB: __________ SEX: M F PHONE: __________

REFERRING DOCTOR INFORMATION

NAME: ____________________

PHONE: ____________________

EMAIL: ____________________

TYPE OF DIGITAL SCAN NEEDED:

☐ CONE BEAM CT ☐ DIGITAL IMPRESSION

REGION(S) TO BE SCANNED:

☐ MAXILLA ☐ MANDIBLE ☐ TMJ ☐ OTHER: ____________________

OPTIONAL PREFERENCES:

☐ STRUCTURE OF INTEREST ____________________

☐ RADIOLOGY REPORT

HOW DO YOU PREFER TO RECEIVE YOUR SCAN FILES?

☐ USB IN MAIL ☐ USB W/ PATIENT ☐ ONLINE FILE TRANSFER

ADDITIONAL INFORMATION/REQUESTS:

PLEASE BRING THIS FORM WITH YOU TO YOUR APPOINTMENT