DENTAL CT SCAN REFERRAL FORM

Note to Patient: Please bring this referral form with you. Payment is due when services are rendered.

Advaced Dental is not responsible for image interpretation, reading of findings.
The diagnosis and treatment planning is the responsibility of the referring doctor.

ADVANCED DENTAL
Phone: (718) 292-8988
237 Willis Avenue, Bronx, NY 10454
Fax: (917) 792-7979

Date: _____/_____/_________

Patient Name: ____ D.O.B _____/_____/_________

Ref. Doctor Name: ____________________________________ Doctor Phone: ___________________

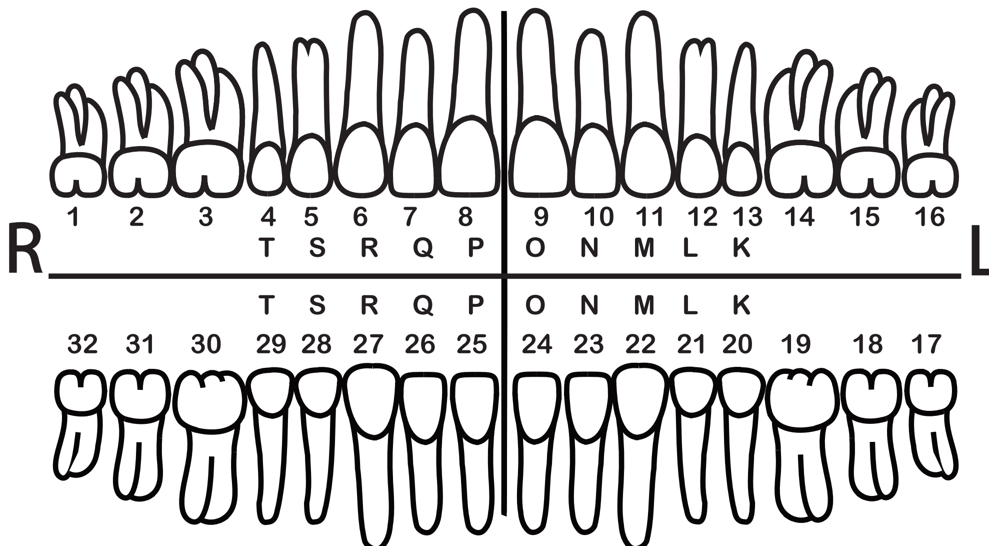
Address: ____

CASE TYPE select one

- ☐ IMPLANT
- ☐ IMPACTION
- ☐ SUPERNUMERARY
- ☐ PATHOLOGY
- ☐ SINUS/ AIRWAYS
- ☐ TMJ STUDY
- ☐ ORTHO
- ☐ OTHER _______________________

Radiology Report Delivery ☐ Paper ☐ E-mail ______________________________
☐ Return to office w/CD ☐ Send w/Patient

REGION OF INTEREST



Special Instructions:

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