melbourne dental xray

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Carlton 3053

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Patient Name _____ D.O.B _____ Sex M ☐ F ☐

Address _____

Examinations

- ☐ O.P.G
- ☐ Lat. Ceph
- ☐ P.A Ceph
- ☐ Bone Age
- ☐ TMJ view 2D

i-CAT Cone Beam CT

- ☐ Endo Survey
- ☐ Unerupted Teeth
- ☐ I.A.C Survey
- ☐ Implant Survey
- ☐ E.N.T Survey
- ☐ T.M.J Survey
- ☐ Ortho Survey (full face)
- ☐ Scan with guide

Clinical Notes

Referrers's details

Date _____ *

Name _____ *

Provider No. _____ *

Signature _____ *

* Legal Requirement

Delivery of images

☐ Post / Deliver ☐ Give to patient

For office use

Patient 3x ID check ☐

Verbal consent obtained ☐

Pregnant Y / N

Breast feeding Y / N

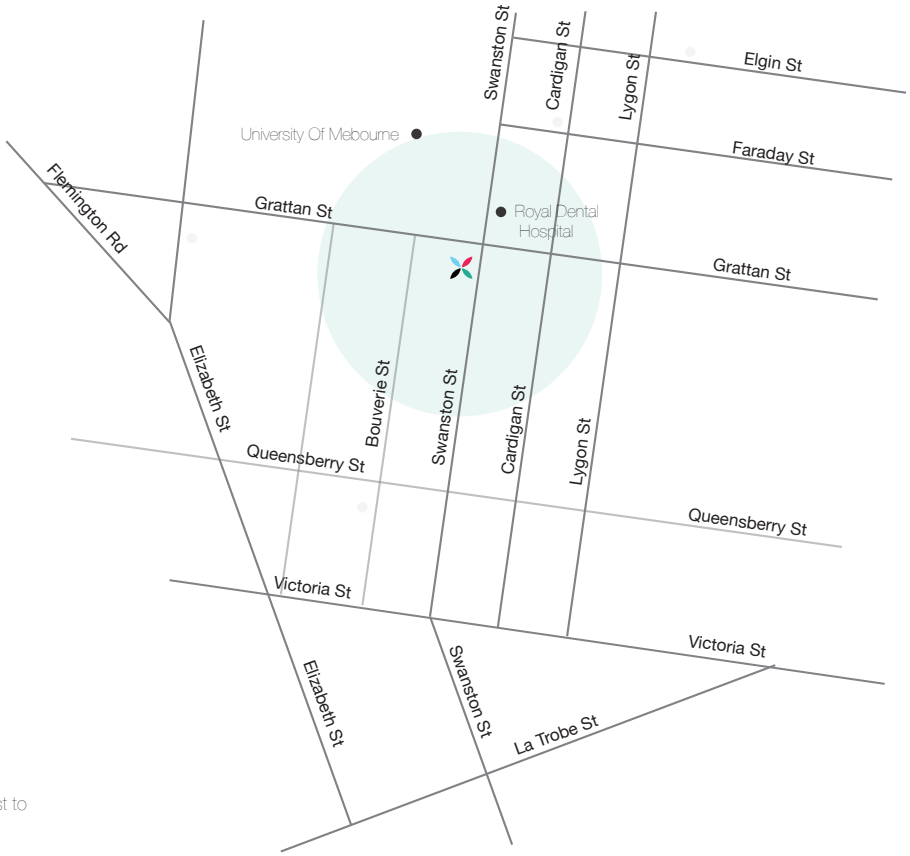
Imaging practitioner

Teeth

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38

Important!

Please present to the clinic with a **signed and dated hard copy** of this request form to be seen on the day.
Appointments are required for all Cone Beam CT.



Your dentist/doctor has recommended that you use Melbourne Dental X-Ray. You may choose another provider but please discuss this with your referrer first to ensure the best outcome for you.