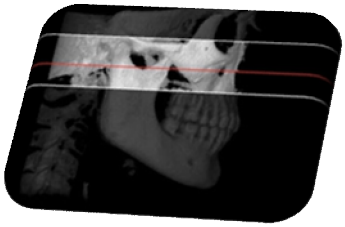
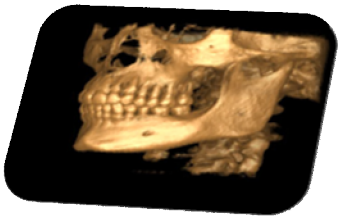


CBCT Dental Imaging Planning Center

Advanced Dental Care of NORTON



REFERRAL FORM

PATIENT INFORMATION:

Name: _____ DOB:_____ Male ____ Female ____

Tel: _____ Email: _____ Address/Town: _____

Today's Date: _____ Appointment Date/Time: _____Consult Date: _____

SPECIFY EXAM:

□ Implant Mandible (specify site) _____ □ Implant Maxilla (specify site) _____

□ CBCT Panoramic View □ Orthodontic Assessment □ Impaction (specify site) _____

□ Endodontic Assessment □ Sinus Assessment □ Airway Assessment □ TMJ

SPECIFY FORMAT: □ 3D NOBEL GUIDE SOFTWARE □ EASY GUIDE □ DICOM ONLY

SPECIAL INSTRUCTIONS:

□ Includes Radiologist's Report $75.00

□ Remove Prosthetics Scan in: □ resting (non-occluding) position □ tight occlusion

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REFERRING DOCTOR:

Name:_____ Signature: _____

Tel: _____ Specialty: _____

Address: _____ Email: _____

PLEASE CALL US AT 508-285-8301 TO SCHEDULE YOUR PATIENT. PATIENT NEEDS TO BRING THIS REFERRAL FORM OR FAX THE FORM TO 508-285-6014.

100 West Main Street Norton, MA 02766
508-285-8301 www.adcofnorton.com