Patient Name: _____ Date (d/m/y): _____

Scan to be Acquired (when): _____

Area of Concern: 8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8
8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8

Reason for scan:

- ☐ Implant Planning
- ☐ Impacted Tooth / Teeth
- ☐ IAN Localization
- ☐ Lesion / Pathology
- ☐ Fractured Tooth
- ☐ Other: _____

Codes:

- ☐ 02931 – one view
- ☐ 02801 – Radiology Report

Scan Size:

- ☐ 5x5 cm
- ☐ 5x8 cm
- ☐ 8x8 cm

Chief Complaint: _____

_____

Referring DDS: _____

- ☐ Follow-up appointment necessary to discuss CBCT findings and treatment plan.