PRACTITIONER DETAILS & DELIVERY ADDRESS

Name of Practitioner:

Practice Name:

Telephone:

Email:

Address:

PATIENT DETAILS

Title:

Forename:

Date of Birth:

Address:

Surname:

Telephone:

2D IMAGING

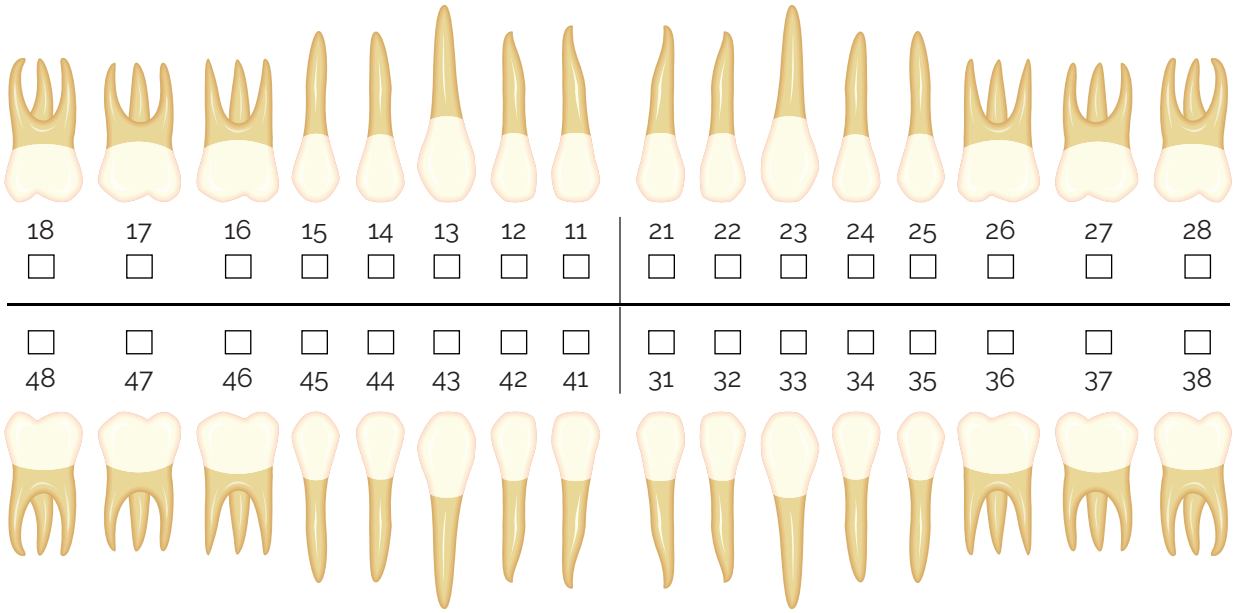
- ☐ Digital Panoramic (OPG)
- ☐ Extra Oral Bitewings

HOW WOULD YOU LIKE TO RECEIVE THE IMAGE?

- ☐ Memory Stick
- ☐ Secure Server

AREA OF INTEREST CBCT ONLY

☐ Sectional (please indicate teeth - 3-4 teeth max) ☐ Mandible ☐ Maxilla ☐ Both Jaws



(If no teeth are selected the whole jaw will be scanned)

Is the patient coming with a radiographic template? ☐ Yes ☐ No

Is the patient possoibly pregnant? ☐ Yes ☐ No

JUSTIFICATION FOR OPG / CBCT:

- ☐ Pre Implant Assessment
- ☐ Wisdom Teeth
- ☐ Other

PAYMENT ☐ Doctor (Please send invoice) ☐ Patient (At the practice)

Signature: _____

☐ I confirm patient has been informed of charge