ROE Dental Laboratory

3D/2D Cone Beam CT
Scan Referral Form
call 216 663 2233
fax 216 663 2237

Referring Doctor: _____

Telephone: _____

Patient Name: _____

Date of Birth: _____/_____/_____

Set Appt. 216 663 2233

Appt. Date: _____

Appt. Time: _____

CBCT Viewer emailed to: _____@_____.com

2nd Viewer emailed to: _____@_____.com

Mail DVD to: _____

_____

Please check purpose for Scan:

- ☐ CT Planning
  - ☐ ROE to plan case
  - ☐ Doctor to plan case
- ☐ Pathology
- ☐ TMJ Exam R / L
- ☐ Dental Impaction
- ☐ Endodontics
- ☐ Sinus Exam
- ☐ Other: _____
- ☐ Jaw Fracture

Scan Appliance Provided? ☐ yes ☐ no

(Scan Appliances are required if patient is receiving 4+ implants, or 50% of teeth include metal-based crowns, or patient is edentulous. Scan appliance design must be ROE fabricated or approved)

Circle area of interest:

Full Scan | Quadrant Scan | TMJ

Payment options: ☐ doctor pays ☐ patient pays (credit card only)

☐ Add to doctor's account

☐ Check Enclosed - Check # _____ (deposit date ___/___/_____ office use only)

☐ Charge my credit card below

Visa / MasterCard / Amex

Card Number _____-_____-_____-_____ (authorization # _____ office use only)

Doctor's Signature: _____ License # _____