3D Oral & Maxillofacial Imaging Center, LLC
11125 Rockville Pike #211, North Bethesda, MD 20852 Phone: 240-221-0797 Fax: 240-560-5358 info@3domi.net

Prescription for Cone Beam CT Imaging

Patient Name: _____Date of Birth: _____
Last First M. Initial

Home address_____

Phone Number: _____ Email: _____

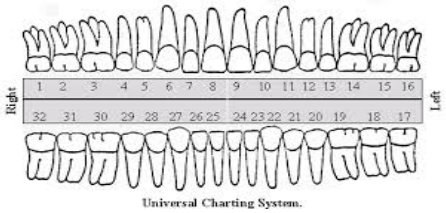
Relevant History:

Please circle the anatomy to be scanned or the area to be scanned:

3D: Maxilla Mandible Both Max/Mand Full Head(17x11 or 17x13.5) Other:____
Maxillary Sinus R or L Ear or Both Ears, R or L TMJ(8x8) or Both TMJ(17x6)

2D: Panoramic, Maxillary Sinus, TMJ (open, at rest, closed, w/ appliance)

for 3D small field of view 5x5cm up to 3 adjacent teeth, specify the location below or teeth#:_____



Special Instructions:_____

Diagnostic Objectives. Please circle:

Implant (w/ radiogr. stent? yes no) Endodontic Impacted tooth Orthodontic TMJ Airway Otolaryngologic Imaging

Specify ___ICD-9/Diagnosis_____

Others_____

CD with Viewing Software and DICOM included with scan: ☐Mail to Doctor ☐Patient ☐Email(™Dropbox)

Please check any applicable: ☐*Radiologist Review* ☐*Rush* ☐*Work-up* ☐*Prints*
☐ *Duplicates sent to*_____
Invoice: ☐Doctor ☐Patient

*We, 3D Oral & Maxillofacial Imaging Center, LLC, are not involved in the diagnosis or the treatment plan/procedure & do not provide the interpretation or the evaluation of images. The work-up with nerve tracing and measurements needs confirmation by the referring doctor.
If you have questions or concerns about our images, please let us know. We will do our best to resolve the issue.

Referring Doctor_____ Phone _____
Last First

_____ _____
Signature of Referring Doctor License # Date