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| **CBCT BOOKING FORM** | | |
| **PT NAME:** | | |
| **SCAN DATE:** | **DOB:** | **PHONE:** |
| **REFERRING CLINIC NAME:**  **REFERRING CLINIC EMAIL:**  **REFERRING CLINIC PHONE:** | | |
| **CLINICAL NOTES:** | | |
| **SPECIFIC FIELD OF VIEW REQUESTED BY DENTIST** (if applicable or on referral): | | |
| **MEDIA REQUIRED** (please circle)**:** DISC (DVD) or USB | | |
| **OFFICE USE ONLY:** Is the referral from Officer Dental Care?   * If yes: Charge CBCT discount $140 * If no: $175 | | |