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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
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