**CBCT Requisition**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s name

|  |  |  |
| --- | --- | --- |
|  |  |  |

First Last

Date of Birth Contact Phone

|  |  |  |
| --- | --- | --- |
|  |  |  |

DD/MM/YY

Mailing Address

|  |  |  |
| --- | --- | --- |
|  |  |  |

Address Line 1

|  |  |  |
| --- | --- | --- |
|  |  |  |

City Province

|  |  |  |
| --- | --- | --- |
|  |  |  |

Postal Code Country

Requesting Doctor’s Name Requesting Doctor’s Phone Number

|  |  |  |
| --- | --- | --- |
|  |  |  |

Requesting Doctor’s email

|  |  |  |
| --- | --- | --- |
|  |  |  |

**CBCT for:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Dental Implant | Pathology | Impacted Tooth | TMJ | Fracture/Trauma | Endodontics | Other |

**Please Indicate Specific Site(s) and/or**

**Anatomical Regions(s) of Interest Clinical Information/Medical History**

|  |  |  |
| --- | --- | --- |
|  |  |  |

Additional information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Note that we will provide the CD with the DICOM (raw data) and InVivo Viewer (data + viewer)***