CBCT Referral

Knoxville Implant Dentistry

Joe F. Griffin, II, D.D.S.

Patient Information

Name_____ _____ _____ Date of Birth _____/_____/_____
(First) (MI) (Last)

Sex (circle one) M F Social Security Number _____ - _____ - _____

If Minor, Parent/Guardian Name _____

Home (____) _____ Work (____) _____ Cell (____) _____

Special Instructions:
❑ STAT ❑ CD
❑ Fax Report

Examination

SimPlant® Dental CT

- ❑ Maxilla
- ❑ Mandible
  - ❑ Mandibular Nerve Mapping
- ❑ Mandible and Maxilla
- ❑ Single Tooth #_____
- ❑ Quadrant (circle one) UR UL LR LL

Patient Should:

- ❑ Wear a Radiographic Template
- ❑ Remove Dentures Before Scan

iCAT Scan

- ❑ Sinuses
  - ❑ Frontal ❑ Maxillary
- ❑ TMJ (circle) R L
  - ❑ Closed ❑ Open/Closed
- ❑ Temporal Bones
- ❑ Facial Bones
- ❑ Mandible
- ❑ Maxilla
- ❑ Mandible and Maxilla
- ❑ Impaction/Supernumerary
- ❑ Other_____

Reason/Symptoms for Exam(s) REQUIRED: _____

_____

Written DX REQUIRED: _____

_____

REFFERING PROVIDER INFORMATION

Signature **(required for exam)** X_____ Date _____/_____/_____

Referring Provider Name_____ Next Appointment with Patient_____/_____/_____

Office Phone (____) _____ Office Fax (____) _____

Send Images to _____ Format (circle one) Pro View One Shot

Address_____ Phone (____) _____ Fax (____) _____