

Patient Name: _____

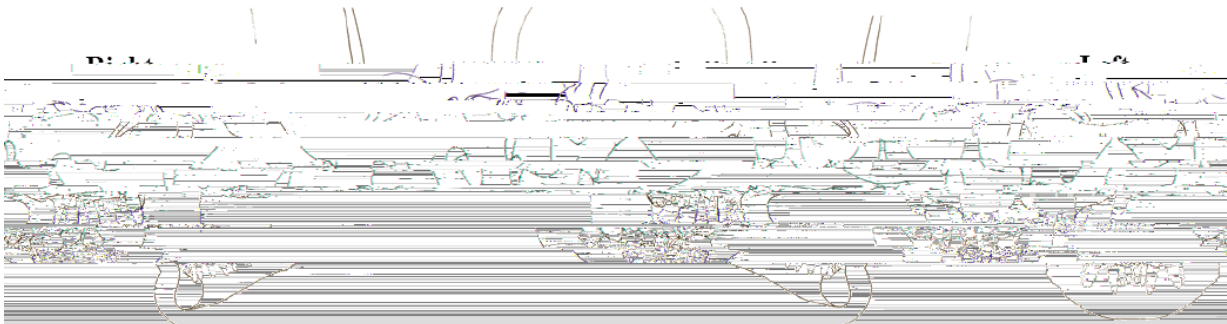
Sex: _____ **Date of Birth:** _____

Note to Patients: Please bring this referral form with you. Payment is due when services are rendered.
Note: CADE Imaging Center is not responsible for image interpretation, reading or findings. The diagnosis and treatment planning is the responsibility of the referring doctor.

3-D Volumetric Imaging: Primary Reason for the Imaging Request:

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Impacted Tooth | <input type="checkbox"/> TMJ Exam | <input type="checkbox"/> Implants |
| <input type="checkbox"/> Miniscrew (TAD) | <input type="checkbox"/> Pathology | <input type="checkbox"/> Sinus Study |
| <input type="checkbox"/> Airway Exam | <input type="checkbox"/> Craniofacial Exam | <input type="checkbox"/> Other: _____ |

Please circle the Region of Interest



Field of View

- Maxilla and Mandible Maxilla only Mandible only TMJ only

Please specify the reason for requesting this image:

By signing below, I request CADE Imaging Center to acquire the images and obtain authorization from the patient for these procedures.

Dr. (Print Name): _____ Phone Number: _____

Mailing Address: _____

Signature: _____ Date: _____