DOCS
DENTISTRY ON CATHERINE STREET

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Patient Information

Prefix _____ First Name _____ Last Name _____ DOB (DD/MM/YYYY) _____

Address _____

City _____ Province _____ Postal Code _____ Phone (Home) _____ Phone (Cell) _____

Email Address _____

Administrative Information

Referring Dentist _____ Ref. Office Name _____ Ref. Office Phone _____

Ref. Office Email Address _____ Date Referred (DD/MM/YYYY) _____

Treatment Information

Please mark teeth or area to be scanned

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38

Cone Beam CT Scan (CBCT)

- ☐ CBCT Scan
  - ☐ Take PAN (Additional Cost)
  - ☐ PAN / PA to be sent

Purpose (Please pick one):

- ☐ Pathology (Please Specify)
- ☐ Pre-Surgical Implant
- ☐ Third Molar Relationship
- ☐ TMJ Scan
  - ☐ Airway Analysis
  - ☐ Orthognathic
  - ☐ Pathology

Report Type (Please pick one):

- ☐ Screening Report and DICOMS
- ☐ Full Report and Image Portfolio
  Includes images, nerve tracings and measurements
- ☐ **Rush Case (48hrs)**

2D Services

- ☐ PAN Interpretation
- ☐ Lateral Cephalometric Scan
  - ☐ with Measurements
- ☐ PA Cephalometric Scan
- ☐ **Rush Case (48hrs)**

Laboratory Services

- ☐ Clinical Photos
- ☐ Digital Impressions
- ☐ Surgical Guide
  (Specify Implant Preference Below)
- ☐ **Rush Case (48hrs)**

Additional Notes

_____
_____
_____
_____
_____
_____
_____
_____

Thank you for your referral!