DENTAL EXAMINATION REQUEST

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PLEASE BRING THIS REQUEST FORM, YOUR MEDICARE CARD OR DVA CARD AND RELEVANT PREVIOUS FILMS.

See bottom of referral form for location map of InCiDental Imaging.

PATIENT DETAILS

Patient's Name: ....

Date of Birth: .... M / F

Medicare No. ....

Address: ....

....

Phone (home) .... (mobile) ....

APPOINTMENT DETAILS

Day: .... Date: .... Time: ....

Region of Interest

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

CLINICAL DETAILS (Please complete)

- ☐ General Diagnostic
- ☐ Unerupted / Impacted Teeth
- ☐ Ortho Planning
- ☐ TMJ
- ☐ Pathology Investigation
- ☐ Other
  (Please specify)
  ....

CONE BEAM 3D

- ☐ Maxilla
- ☐ Mandible
- ☐ TMJ
- ☐ Specific Area

(Please specify region required)

....

EXAMINATION REQUIRED

- ☐ OPG
- ☐ Lateral Cephalostat
- ☐ Hand Wrist Skeletal Age
- ☐ Periapical Films
  (Please specify areas)
- ☐ Bite Wing Films
- ☐ Full Mouth Survey

FILMS / CD

- ☐ Patient to take
- ☐ Collect
- ☐ Deliver

REFERRING DOCTOR'S DETAILS

Doctor's Name: ....

Address: ....

....

....

Provider No. ....

Phone: .... Fax: ....

Email: ....

Signature: ....

Date: ....

☐ Tick this box if you do not want your scans to be used by InCiDental Imaging for educational, research and / or promotional purposes.