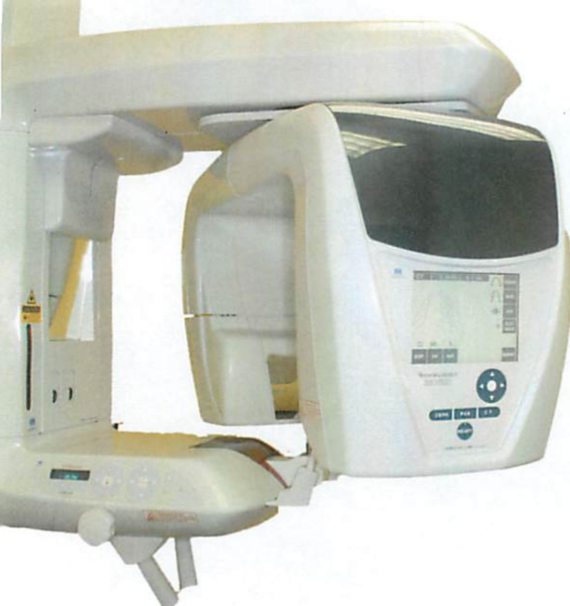

SILBERMAN
ENDODONTICS

3D-CBCT Referral Form

Patient's Name: ______________________ Appointment Date: ____________
D.O.B: ____________ Appointment Time: ____________
Phone: ____________
Address: ____

Please select the exposure of interest:
Panoramic ________ CT __________

CT Exposure sizes (FOV):
40 x 40 mm ____________ (Endo) 40 X 80 mm ___________ (Endo)
100 x 50 mm ________ (Maxillary) 100 x 50 mm _______ (Mandible)
100 x 80 mm _______ (Both arches)

PLEASE INDICATE THE TOOTH OR THE REGION OF INTEREST:

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

Other Services:
Radiology Report: _____

Additional Comments:

____

____

Referring Dentist: ____________________
Phone: ____________________
E-mail: ____________________

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