Advanced Endodontics
Repairing and restoring function • Preserving and renewing smiles

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CBCT/ Panoramic Scan Request

Patient Name:_____

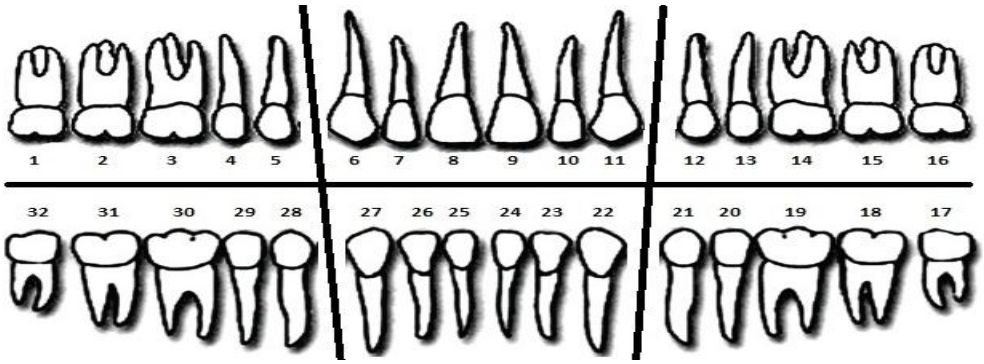
Appointment: Date: _____ Time: _____ am pm

Reason for Request:_____

CBCT Only

❑ Please perform a CBCT scan of tooth/teeth or area (one sextant - 50 mm x 37 mm): *please circle below*

❑ Please perform a CBCT scan of entire arch (combines three sextants to construct one larger image – 75 mm x 37 mm): ❑ Maxilla ❑ Mandible ❑ Both (will be on two separate CD's)



Panoramic Only

❑ Please perform digital panoramic radiograph:
Send by: ❑ CD ❑ Printed ❑ Office email on file ❑ Other email:

_____

Signature and Acknowledgement

Bradley A. Hirschman DDS, MS, individually, and on behalf of Advanced Endodontics PC ("PC") will have the requested images read by a medical or dental radiologist whose report will be forwarded directly to me, the referring doctor. I understand that Dr. Hirschman's involvement in connection with this referral is limited to taking the x-ray. Dr. Hirschman, and employees of the PC will not participate in any interpretation of the images; the preparation and issuance of the report; communicating the results of the study to the patient; or counseling the patient on appropriate follow-up as may be required in the exercise of my clinical and professional judgment. By executing this referral form, I understand, acknowledge and accept the responsibility that as the referring doctor it is my sole responsibility to communicate the results of the study to the patient and to provide appropriate consultation and follow-up with the patient, and I further agree to protect, defend, indemnify and hold Dr. Hirschman and the PC completely harmless in discharging those responsibilities to the patient. I understand that no doctor-patient relationship between my patient and Dr. Hirschman is formed as a result of his office taking this image.

_____ _____

Referring Doctor Signature / Print Name ***Date***