DentalCT
CAMBRIDGE

114 Regent Street, Cambridge, CB2 1DP
Tel: 01223 324 524 | info@dentalctcambridge.co.uk

PRACTICIONER DETAILS & DELIVERY ADDRESS

Name of Practitioner:
Practice Name:
Address:
Telephone:
Email:

PATIENT DETAILS

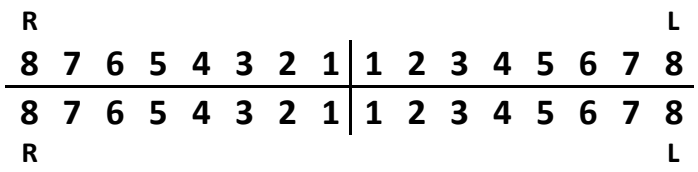
Title: Mr / Mrs / Miss / Dr / Other:	☐ Male ☐ Female
Forename:	Surname:
Date of Birth: / /	Telephone:
Address:	
Post code:	Email:

SERVICE REQUIRED

☐ 2D Panoramic OPG	☐ 3D CBCT

AREA OF INTEREST – CBCT ONLY

☐ Single tooth (50mm x 50mm)
☐ Single arch (80mm x 50mm)
  ☐ Mandibula
  ☐ Maxilla
☐ Both arches (80mm x 80mm)



Is the patient coming with a radiographic template? ☐ Yes ☐ No
Is the patient possibly pregnant? ☐ Yes ☐ No

FORMAT REQUIRED

☐ Romexis format + viewer	☐ DICOM files
☐ Image files (OPG only)	

OUTPUT

☐ USB	☐ Email (OPG only)

RELEVANT MEDICAL HISTORY / JUSTIFICATION FOR X-RAY

☐ Implants ☐ Bone Graft ☐ Impacted Teeth ☐ Endodontics ☐ Sinus Exam	Other:

Special instructions:

Signature: