



1685 Crown Ave  
 Lancaster, PA 17601  
 (717) 481-7645

## Prescription for Cone Beam CT Imaging

Instructions: Please fill this form, print it and provide it to the patient. Fields with an \* are mandatory.

Patient Identification			
Last Name*	First Name*	Date of Birth (mm/dd/yyyy)*	
Home Address			
City	State	ZIP Code	Phone Number*

Relevant History

Anatomy to be Scanned*
Maxilla <input type="checkbox"/> Mandible <input type="checkbox"/> Both <input type="checkbox"/> Quadrant <input type="checkbox"/> Specify <input type="text"/> TMJ <input type="checkbox"/>

Diagnostic Objective*
Implant Imaging <input type="checkbox"/> Teeth/Quadrant/Arch <input type="checkbox"/> Radiographic Stent provided <input type="checkbox"/> Measurements for implant site required <input type="checkbox"/> Pathology Evaluation <input type="checkbox"/> Impacted tooth Evaluation <input type="checkbox"/> Maxillary Sinus Evaluation <input type="checkbox"/> Endodontic Evaluation <input type="checkbox"/> List Teeth <input type="text"/> Orthodontics <input type="checkbox"/>
TMJ Study <input type="checkbox"/> Closed <input type="checkbox"/> Open <input type="checkbox"/> Both <input type="checkbox"/>
Other Diagnostic Objective <input type="checkbox"/> Specify <input type="text"/>

Special Instructions

Referring Doctor			
Last Name*	First Name*	Phone Number*	
Office Address			
City	State	ZIP Code	Email
Signature		Date*	

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