



# Orange County Specialty Dental Group

## 3D Cone Beam CT Scan and Panoramic Referral Form

J Morita USA, i-Dixel 2.0 Software

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

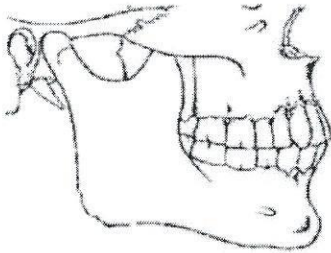
Telephone #: \_\_\_\_\_ Appointment Date & Time: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_

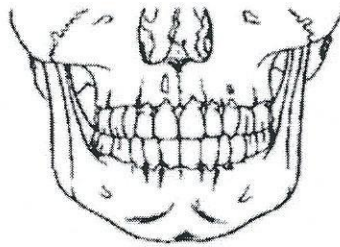
Please check purpose for Imaging:

- |                                           |                                          |                                      |
|-------------------------------------------|------------------------------------------|--------------------------------------|
| <input type="checkbox"/> Dental Impaction | <input type="checkbox"/> Pathology       | <input type="checkbox"/> Endodontics |
| <input type="checkbox"/> TMJ Exam R/L     | <input type="checkbox"/> Dental Implants | <input type="checkbox"/> Other _____ |
|                                           |                                          | _____                                |

Circle the area of interest:

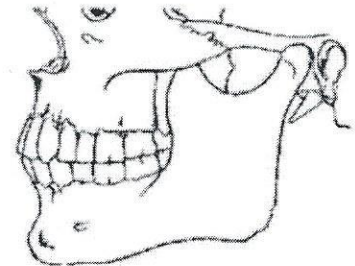


R



R

L



L

Implants: \_\_\_\_\_ Area of Interest: Mandible: \_\_\_\_\_ Maxilla: \_\_\_\_\_

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

Orange County Specialty Dental Group will include a CD Rom containing digital images of the CBCT along with i-Dixel 2.0 Software for the areas of interest. These files are sent to the referring Doctor via U.S. Mail.

Orange County Specialty Dental Group does not provide interpretation of these scans. Your Dentist will interpret the information for you.

Doctor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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