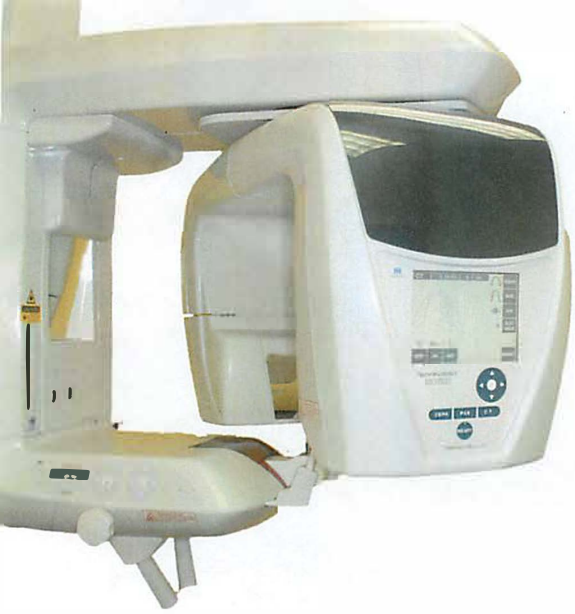

SILBERMAN
ENDODONTICS

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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frontdesk@silbermanendodontics.com