Kerrville
Oral & Maxillofacial Surgery
Implants, Extractions, Facial Reconstruction

Radiology Request Form

Today's Date: _____ Date Imaging Needed: _____

Patient Name: _____ Date of Birth: _____

Patient's Phone Number: _____

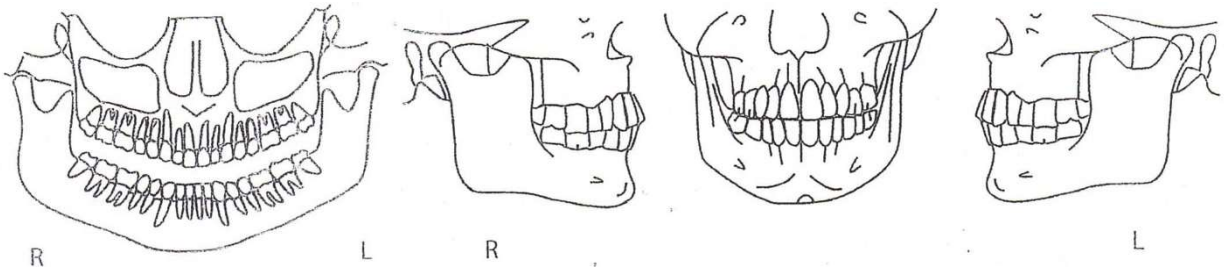
Please check purpose for imaging:

- o Dental Impaction
- o TMJ
- o Pathology
- o Implants #_____
- o Trauma
- o Sinus
- o Other _____

Please check type of imaging:

- o Full CBCT $275
- o Focal CBCT $125
- o Panograph $125

Area of interest:



RIGHT			A	B	C	D	E	F	G	H	I	J			LEFT
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
			T	S	R	Q	P	O	N	M	L	K			

Provide imaging on (please check one): CD/DVD _____, USB _____, Online/Cloud _____

Comments:_____

_____

_____

Requesting Doctor's Name and Signature: _____

Kerrville OMS, PLLC does not provide interpretation of these scans, your referring Dentist will interpret the information for you. Kerrville OMS, PLLC will send the digital images (.dcm files) of the CBCT or panograph with EzDent-I Imaging software to your referring Dentist.

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