Clear Print

Kornberg School of Dentistry
TEMPLE UNIVERSITY®

Department of Oral and Maxillofacial Pathology, Medicine and Surgery
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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 ☐ Mandible ☐ Both ☐ Quadrant ☐ Specify TMJ ☐

Diagnostic Objective*

Implant Imaging ☐ Teeth/Quadrant/Arch ☐ Radiographic Stent provided ☐ Measurements for implant site required ☐

Pathology Evaluation ☐ Impacted tooth Evaluation ☐ Maxillary Sinus Evaluation ☐

Endodontic Evaluation ☐ List Teeth Orthodontics ☐

TMJ Study ☐ Closed ☐ Open ☐ Both ☐

Other Diagnostic Objective ☐ Specify

Special Instructions

Referring Doctor

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

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