CBCT Scan Request Form

Patient details:

Title: First name: Last name:

Address:

Postcode:

Tel (h): Tel (w):

Mobile: Email:

Preferred contact method: DOB: / /

Referring Dentist details: N.B. Please complete all fields

Dentist name: Practice:

Practice address:

Postcode: Practice Tel:

Email:

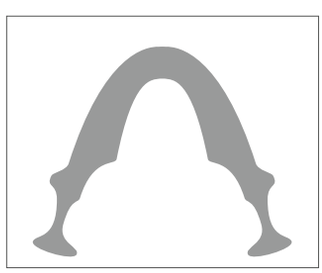
Brief patient history:

Reason for scan:

CBCT scan requirements:

All scans will be parallel to the occlusal plane unless otherwise specified. Radio-opaque marker to be worn? Yes ◯ No ◯

Field of View:
- ◯ Full upper ◯ Full lower
- ◯ Full upper and lower
- ◯ Full upper and lower, inc TMJ
- ◯ Sectional (50x50mm) Please mark area(s) on diagram below



CBCT scan charges Cd Only £100

Dentist Signature: _____ GDC Number: _____

STANDARD IMAGE RESOLUTION WILL BE SUPPLIED UNLESS YOU SPECIFICALLY REQUEST HIGH RESOLUTION OR ENDO (50X50mm FOV only)

Assistance with case planning - Price on application.
YOUR PATIENT WILL BE ASKED TO PAY FOR THEIR SCAN AT THEIR APPOINTMENT UNLESS YOU INSTRUCT US OTHERWISE.

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