



**DENTAL IMAGING REFERRAL FORM**

**REFERRING DENTIST INFORMATION**

Full Name: ..... Date Referred: .....  
Address: .....  
Telephone: ..... E-mail: .....

**PATIENT INFORMATION**

Patient's Name: ..... Date of Birth: .....  
Patient's Address: .....  
Home Tel: ..... Mobile Tel: .....  
(Check all that apply)

**REASON FOR REFERRAL:**

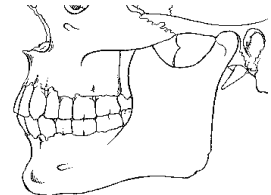
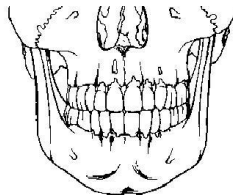
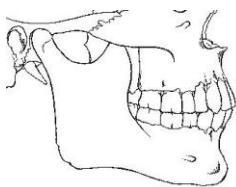
TMJ Assessment     Sinus Assessment     Airway Assessment  
 Endodontic Assessment     Implant Assessment     Implant Surgical Placement Only  
 Implant Surgical Placement & Restoration     Implant Problems & Diagnosis  
 Augmentation & Surgical Placement     Entire Maxillofacial Region     Orthodontic  
 Oral Pathology     Impaction    Other: \_\_\_\_\_

Cone Beam CT     Digital Panoramic     Cephalometric

**Region(s) of Interest:**

.....  
.....

**Circle Area:**



**FORMAT DATA DELIVERY OPTIONS FOR SCAN:**

DICOM CD  
 E-MAIL  
 PRINTS  
 DUPLICATE CD NEEDED

Other: .....

**PAYMENT:**  Referrer     Patient

Please send by FAX to 856-428-7644 or SCAN and EMAIL, RE: Patient Referrals to:  
[cherryhilldentalexcellence@gmail.com](mailto:cherryhilldentalexcellence@gmail.com)

**ONCE COMPLETED HAVE PATIENT CALL TO SCHEDULE AN APPOINTMENT**