

# Cone Beam CT Imaging Request

**Dr. Maico Melo, Inc.**

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Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
M D Y

Address: \_\_\_\_\_ City: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Referred by: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Xray Enclosed: PAN \_\_\_\_\_ PA \_\_\_\_\_ Other \_\_\_\_\_ None \_\_\_\_\_

## Dental Insurance:

### Plan#1

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Plan \_\_\_\_\_ Gr# \_\_\_\_\_ ID# \_\_\_\_\_ Dep# \_\_\_\_\_

### Plan#2

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Plan \_\_\_\_\_ Gr# \_\_\_\_\_ ID# \_\_\_\_\_ Dep# \_\_\_\_\_

## Reason for Study/History:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Area of Interest:

\_\_\_\_\_  
\_\_\_\_\_

**PANORAMIC VIEW**

**IMPLANT**

**Maxilla**

List area for imaging slices \_\_\_\_\_

**Mandible**

List area for imaging slices \_\_\_\_\_

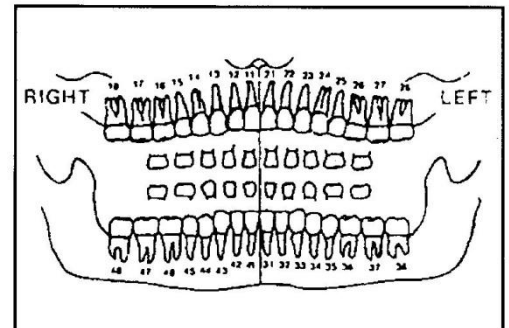
**Combined Maxilla/Mandible**

List area for imaging slices \_\_\_\_\_

**Radiographic stent supplied with this referral**

**TMJ** – includes bilateral TMJ imaging, sagittal cross sections, coronal view and panoramic image

**Orthodontics** - includes PA, lateral cephalometrics and panoramic image



*Dr. Maico Melo produces these images for your review upon your request. However, the responsibility for diagnosis and management is the responsibility of the referring doctor.*