307-733-4778
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Dental CT Scan Referral Form

Note to patient: Please bring this referral form with you. Payment is due when services are rendered.

Larsen Family Dentistry is not responsible for image interpretation, reading of findings. The diagnosis and treatment planning is the responsibility of the referring doctor.

Date: _____

Patient Name: _____ Date of Birth: _____

Referring Doctor: _____ Doctor/Office Phone Number: _____

Email: _____

Specify Exam:

- Mandibular Scan
- Maxillary Scan
- TMJ Scan
- Full Dental Arch Scan

Case Type: (select one)

- Implant
- Impaction
- Supernumerary
- Pathology
- Sinus/Airways
- TMJ Study
- Other

Scan Options:

- 2D photos sent via Email
- CD with DICOM file sent with patient

Special Instructions:

_____

_____

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