

Kincardine Dentistry CT Referral Form

Name: _____
First Last

DOB: ____/____/____ Gender: F / M/ O
DD MM YYYY

Address: _____
Street

_____ Town Postal Code

Home Number: _____

Cell Number: _____

Email address: _____

Contact person: _____

Referral Date: _____

Dentist: _____

Office: _____

_____ Street Town

_____ Postal Code Office number

_____ Email

Please provide patient's next appointment:
 (If applicable) _____

Cost of scan: \$250.00 per view

(Includes: A radiographic report by the oral radiologist)

Circle area of CBCT scan of 5x8cm or less by circling teeth to be included in CBCT

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

Date of x-ray: _____

Please check which radiologist

- Canaray (reading in 100days unless expedited)
- Orad (reading in 14days(written report only))

Expedite CBCT (please circle)

1-2 Days \$115 3-6 Days \$75

7-12 Days \$50 12-17 Days \$25

- Make measurements as well \$35

Reason for CBCT (Required be filled out as well as an x-ray)

Please fax or email this completed form, forward x-ray and we will contact the client to arrange appointment.

Kincardine Dentistry



6 Millennium Way Kincardine ON N2Z 0B5

info@kincardinedentistry.com

Fees are due at the end of the appointment. We accept cash, cheque, debit card, Visa and Mastercard. Data and reports will not be released prior to full payment.

