University Dental Associates (Faculty Practice) CBCT Interpretation Request

Download this form, complete, and submit online with accompanying radiographs.

Date: _____

Referring Clinic Information

Referring Clinic/Doctor: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ E-mail (Optional): _____

Patient Information

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Radiograph Information

Date Taken: _____

Reason for CBCT scan:

Additional Information: