

Date of Appointment:

Time:

**MAXILLOFACIAL DIAGNOSTIC IMAGING SERVICES**

One Kneeland Street, Boston MA 02111

**Cone-Beam Computed Tomography (CBCT) Referral**

**Referring Dentist Information**

Name: \_\_\_\_\_ Dept. \_\_\_\_\_

Telephone No.: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
Street City State Zip Code

**Patient Information**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Axium# \_\_\_\_\_

Home Address: \_\_\_\_\_  
Street City State Zip Code

Telephone No.: ( ) \_\_\_\_\_ ( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
HOME WORK CELL

**CBCT Requested**

**Implant:**

- Maxillary
- Mandible
- Scan with Stent (*patient wearing stent*)
- Scan without Stent (*patient not wearing stent*)
- Scan Stent Only

**Full Scan with TMJ**

**Orthodontics**

**Maxillofacial Pathology**

- Maxillary  Mandible

**Sectional Scan (*includes small area of jaw*)**

- Tooth # \_\_\_\_\_

**Clinical information / diagnosis / other relevant information for the Maxillofacial Radiologist:**

**Fees: 1 Jaw - \$258    Both Jaws - \$309    Sectional - \$129**

**\*\*FOR APPOINTMENTS or QUESTIONS CALL: 617- 636-6812\*\***

**\*\*PLEASE FAX THIS FORM TO: 617-636-6834\*\***