School of Dental Medicine

For Office Use Only

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

- ❑ **Only For Implants:**
  - ❑ Maxillary
  - ❑ Mandible
  - ❑ Scan with Stent (*patient wearing stent*)
  - ❑ Scan without Stent (*patient not wearing stent*)
  - ❑ Scan Stent Only **$60 fee**
- ❑ **Full Head Scan with TMJ**
- ❑ **Orthodontics**
  - ❑ Maxillary ❑ Mandible ❑ Full Head
- ❑ **Maxillofacial Pathology or Other**
  - ❑ Maxillary ❑ Mandible Specific Site/Area:

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

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Fees: One Arch - $347 Both Arches - $404
Full Head - $518

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

*****PLEASE FAX THIS FORM TO: 617-636-3760 or EMAIL: cbct@tufts.edu*****

Updated 5/4/2017