Tufts UNIVERSITY | School of Dental Medicine

For Office Use Only

Date of Appointment:

Time:

MAXILLOFACIAL DIAGNOSTIC IMAGING SERVICES

One Kneeland Street, Boston MA 02111

Radiography 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

Radiography Requested

- ❑ **Panoramic**
- ❑ **Full Mouth Series (FMX)**
- ❑ **Cephalometric**
  - ❑ Lateral Ceph ❑ PA Ceph
- ❑ **Periapical (PA)**
  - ❑ Tooth #_____
- ❑ **Bitewing (BW):**
  - ❑ **RT Molars**
  - ❑ **RT Premolars**
  - ❑ **LT Molars**
  - ❑ **LT Premolars**

Fees: Panoramic-$70 FMX-$81 Cephalometric-$82 Periapical-$25

Bitewing: 1BW-$17 2BWs-$34 3BWs-$43 4BWs-$51

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

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

Update: 5/4/2017