ORAL MAXILLOFACIAL IMAGING CENTRE CALGARY

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Services provided by Specialist in Oral Maxillofacial Radiology

Patient name:_____ **D.O.B.:** _____
Please Print DD/MM/YY

☐**Male** ☐**Female** For female patients: Is pregnancy a possibility? ☐ Yes ☐ No

Address:_____ **Tel:** _____

Referring Dr's Name:_____ **Dr's Signature:** _____ **Tel:** _____

Date:_____ ☐**Charge Dr.** ☐**Charge Patient**

*24 Hour notice of cancellation requested. Payment is required at the time of service. (Debit, Visa, M/C, Cash, Cheques with credit card ID)

New Tom VGi Volumetric Scan

☐TMJ Survey: _____
☐TMJ Survey: with additional positions (please specify):_____
☐Implant Study Maxilla (sites):_____
☐Implant Study Mandible (sites):_____
☐Upper Airway Investigation/Sinuses:_____
☐Lesion Investigation in the Maxillofacial Complex:_____
☐Localization Study/Impacted, Supernumerary Teeth:_____
☐STENT:
- ☐To be sent to our office:_____
- ☐Patient to bring to appointment:_____

☐External CBCT (Reformatting/Interpretation):
☐MRI Interpretation
☐Disc/DICOM Only, with report on incidental findings

Notes: _____

Orthodontic Records

☐Initial ☐Progress ☐Final
☐Panoramic ☐Lateral Cephalometric ☐P-A Cephalometric ☐Hand/Wrist
☐Cephalometric Analysis (please specify) _____

General Dental Records

☐Panoramic ☐Full Mouth Survey ☐Periapicals (specify area) _____

Occlusal (please specify) ☐Mandibular standard ☐Mandibular anterior
☐Maxillary vertex ☐Maxillary standard ☐Maxillary lateral

☐Radiologic Interpretation on films from other sources _____
☐Duplication of radiographs _____
Notes: _____

For appoinments please call: (403) 547-OMIC (403) 547-6642 Fax: (403) 547-6607