Fourth Ave Endodontics
Dr. Scott Loomis DMD | MSD | CERT. (ENDO)

CBCT Referral

Patient Name: _____ Date of Birth (dd/mm/yyyy): _____

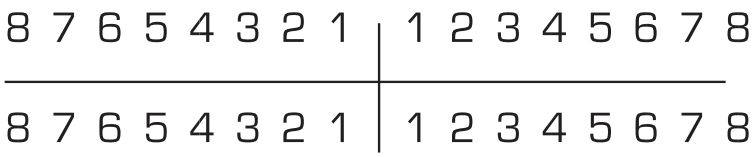
Home Phone: _____ Cell Phone: _____

Referred by: _____ Date: _____

Other Dentists to receive copies of report:

Dentist/Office	Contact information

Area of interest:



Scan type requested: _____

Pertinent Clinical Information (ie. Case history, provisional diagnosis, proposed treatment...)

Please provide any recent radiographs or other images of the area of clinical interest.

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