CBCT Scan Referral Form

IDEAL ENDODONTICS

Referring Doctor: _____

Patient Information

First Name: _____ Last Name: _____

Date of Birth: _____ Office Chart#: _____
(optional)

Contact Information

Home Phone: _____

Work Phone: _____

Mobile Phone: _____

Special Instructions: _____

_____

_____

_____

Send by: ☐ CD ☐ Printed ☐ Office email on file ☐ Other: _____

Signature and Acknowledgement

I understand that Ideal Endodontics' involvement in connection with this referral is limited to taking the scan. Ideal Endodontics and employees of the practice will not participate in any interpretation of the image; the preparation and issuance of the report; communicating the results of the study to the patient; or counseling the patient on appropriate follow-up as may be required in the exercise of my clinical and professional judgment. By executing this referral form, I understand, acknowledge, and the responsibility that, as the referring dentist it is my sole responsibility to communicate the results of the study to the patient, and to provide appropriate consultation and follow up with the patient. I further agree to protect, defend, indemnify and hold Ideal Endodontics completely harmless in discharging those reponsibilities to the patient. I understand that no doctor-patient relationship between my patient and Ideal Endodontics exists because of their office taking this image.

_____ _____

Referring Dentist Signature/Print Name Date