IDEAL ENDODONTICS

Notice of Non-Read Cone Beam Computerized Tomography (CBCT) Scan

Referring Doctor: _____

Patient Information

First Name: _____ Last Name: _____

Date of Birth: _____

Signature and Acknowledgement

Patient's initials required

_____ I understand that _____ involvement in connection with this referral is limited to taking the scan.

_____ _____ and employees of the practice will not participate in any interpretation of the images; the preparation and issuance of the report; communicating the results of the study; or counseling the patient on appropriate follow-up as may be required in the exercise of clinical and professional judgment.

_____ By signing this form, I understand, acknowledge and accept that my referring dentist has the sole responsibility to communicate the results of the study to me and to provide appropriate consultation and follow-up.

_____ I understand that _____ will be responsible for reviewing, evaluating, and diagnosing the imaging data.

_____ Furthermore, I understand that no doctor-patient relationship between _____ and me is formed because of his or her office taking this image.

_____ _____

Patient or Patient's Representative Signature Date

_____ _____

Witness' Signature Date