The Dental Center at Western University of Health Sciences

795 E. Second Street, Suite 8
Pomona, CA 91766-2007
Tel: (909) 706-3910 • Fax: (909) 469-8650

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## Oral Maxillofacial Radiology Referral Form
## 795 E. Second Street. 3rd floor, Suite 8 Pomona, CA 91766
## Tel: (909) 706-3910 FAX: (909) 469-8650

****Referring Doctor: Please fill out completely and fax a copy of this request form prior to patient appointment. Patient: Please call Monday – Friday 9:00 am - 4:30 pm to schedule an appointment ***.*

Today's Date: _____

**PATIENT INFORMATION:**
Name: _____ D.O.B.: _____ Male: ☐ Female: ☐
Telephone: _____

**REFERRING DOCTOR:**
Name: _____
Address: _____
Telephone: _____
Email: _____
Signature: _____

**PROCEDURES REQUESTED (check all that apply)**
☐ Lateral Ceph ☐ Panoramic ☐ Full Mouth X-rays

**CONE BEAM CT (check all that apply):**
☐ Small volume- one to few teeth
☐ Medium volume -Mandibular
☐ Medium volume - Maxillary
☐ Large volume - both jaws

*SPECIFY EXAM (required information)*
Implant (specify site):_____
Orthodontic Assessment (specify site): _____
Endodontic Assessment (specify site): _____
Sinus Assessment (specify site): _____
TMJ: (specify site) : _____

Special Instructions:_____
_____
_____
_____
_____

***Payment is due at the time services are rendered*

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