

PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRE

DATE OF SERVICE:

REFERRING PHYSICIAN/PHONE NUMBER:

PATIENT NAME:

SOCIAL SECURITY #:

Account Number:

DOB:

AGE:

FEMALE / MALE (PLEASE CIRCLE)

ARE YOU OR COULD YOU BE PREGNANT? YES NO

DATE OF LAST MENSTRUAL CYCLE: ___/___/___

IF YOU ARE PREGNANT, PLEASE NOTIFY THE TECHNOLOGIST IMMEDIATELY

DID YOUR DENTIST PROVIDE A STENT (DENTURE WITH MARKER)
TO WEAR SPECIFICALLY FOR THIS SCAN?

YES NO

IF YOU WEAR DENTURES, DO YOUR DENTURES CONTAIN ANY METAL PLATES? YES NO NOT SURE

ARE YOU HAVING THIS TEST TO DETERMINE IMPLANT PLACEMENT?

YES NO

IF NO, PLEASE EXPLAIN WHY YOU ARE HAVING THIS DENTAL SCAN:

THIS DENTAL SCAN IS NOT COVERED BY MEDICAL INSURANCE.

PAYMENT MUST BE MADE AT TIME OF SERVICE.

PLEASE DIRECT ANY QUESTIONS YOU MAY HAVE TO THE TECHNOLOGIST PERFORMING YOUR TEST.

I ATTEST THAT THE INFORMATION PROVIDED ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE OF PATIENT OR GUARDIAN OR PERSON AUTHORIZED TO CONSENT FOR PATIENT

TECHNOLOGIST NOTES:

TECH SIGNATURE