HIGH PLAINS
Periodontics
and Implant Dentistry

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IMAGING SERVICES REFERRAL FORM

Please complete this form in its entirety.
If this form is incomplete, imaging services will not be provided.

Referring physician: _____

Patient name: _____

Reason for Imaging Request (please circle all that apply)

Maxilla Mandible Both Arches

Implants TMJ Sinus Dental Alveolar Maxillofacial Pathology / Trauma

Other reason(s) not listed above (please describe):_____

_____

_____

High Plains Periodontics, PLLC, agrees to have the images read by a medical or dental radiologist and will forward a copy of the report to the referring healthcare professional, who will take full responsibility for the radiological interpretation of the images and hold High Plains Periodontics, PLLC, harmless in the event that the appropriate follow-up is not given to the patient.

Imaging services means CBCT imaging services, which are limited to the head and neck region and limited to CT imaging without contrast.

In order for these services to be provided, the referring healthcare professional agrees to the provisions of the imaging services referral form. **It is mandatory that the referring healthcare professional sign and date below.**

Signature:_____ Date:_____

Printed Name:_____