Diamond Bar
Dental Imaging Center

(909) 396-6400
Fax: (888) 711-3752

1111 S. Grand Ave. Suite I-2, Diamond Bar, CA 91765

DATE: _____

TIME: _____

NAME: _____

REFERRING DR.: _____

ORTHODONTIC SURVEYS

☐ Beginning ☐ Progress ☐ Final

☐ Ceph. Analysis: _____

INDIVIDUAL PROCEDURES

- ☐ Full Mouth Series (*FMX*)
- ☐ Burn x-rays & photos to CD
- ☐ Bitewings
- ☐ Panoramic X-Ray
- ☐ Carpal Index
- ☐ Color Photographs
- ☐ Lateral Ceph.
- ☐ PA Ceph.

SPECIAL INSTRUCTIONS

_____

_____

_____

Dr. _____

Cone Beam Volumetric Tomography

- ☐ **TMJ** - closed (*L & R*)
- ☐ **TMJ** - closed & wide open (*L & R*)
- ☐ **TMJ** - add'l view
- ☐ **Impacted** - tooth # _____
- ☐ **Implant -** ☐ - Maxilla ☐ - Mandible

Radiographic Stent Provided
☐ - Yes ☐ - No

IMPLANTS

Upper Arch
☐ Right Side ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
☐ Left Side 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

Lower Arch
☐ Right Side ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
☐ Left Side 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

Send images using the following:
- ☐ CD-ROM
- ☐ DICOM file
- ☐ Prints on paper
- ☐ Radiology report
- ☐ Via e-mail

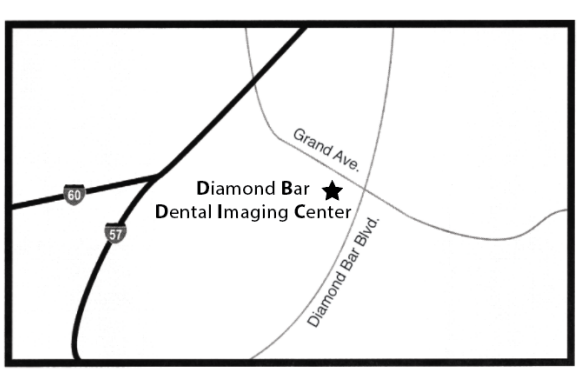
Website: www.diamondbardentalimagingcenter.com • Email: info@diamondbardentalimagingcenter.com

Signature and Acknowledgement

I understand that Diamond Bar Dental Imaging Center involvement in connection with this referral is limited to taking the scan. Diamond Bar Dental Imaging Center 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 to the patient; or counseling the patient on appropriate follow-up as may be required in the exercise of my clinical and professional judgement.
By executing this referral form, I understand, acknowledge, and accept 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 Diamond Bar Dental Imaging Center completely harmless in discharging those responsibilities to the patient. I understand that no doctor-patient relationship between my patient and Diamond Bar Dental Imaging Center exists because of his or her office taking this image.

_____ _____

Referring Dentist Signature/Print Name Date



1) It is highly appreciated if you would show up on time for your appointment, also in respect to other patient's appointment time.
2) Kindly give us at least 24 hour notice for cancellations.
3) Kindly brush your teeth and comb your hair, for us to be able to take amazing photographs.
4) Payment is required at the time of the appointment. We do not bill insurance but we are happy to provide you some assistance with what you need for possible reimbursement.
5) Please call us for any questions you may have.