TEXAS A&M UNIVERSITY
College of Dentistry

Oral and Maxillofacial Imaging Center
3000 Gaston Ave, Suite 506A, Dallas, Texas 75246
Telephone: (214) 828-8479 Email: CODImagingCenter@tamu.edu

CBCT INTERPRETATION REQUEST

Patient Name: _____

Address: _____

Date of Birth: _____

Sex: _____

Doctor:

☐ **GP** ☐ **Endo** ☐ **ENT** ☐ **OMFS** ☐ **Ortho** ☐ **Pedo** ☐ **Perio** ☐ **Other:** _____

Address: _____

Tel: _____

Fax: _____

Email: _____

Date: _____ **Date of study:** _____

TO BE COMPLETED BY PHYSICIAN/DENTIST

Pertinent History: _____

_____

Signs, Symptoms, Relevant Diagnosis: _____

_____

Specific question(s) to be answered by this study: _____

_____

Patient pregnant? ☐ **Yes** ☐ **No**

Physician/Dentist (Print name): _____

Physician/Dentist (Signature): _____ Date: _____

E-mail completed form to: CODImagingcenter@tamu.edu