Robert W Heydrich, DMD, MS

Edgewater ENDODONTICS
YOUR ROOT CANAL SPECIALISTS

CBCT/ Panoramic Scan Request

Patient Name:_____

Appointment: Date: _____ Time: _____ am pm

Please list tooth/teeth or area for endodontic evaluation and/or treatment: _____

Comments: _____

_____

CBCT Only

❑ Please perform a CBCT scan of tooth/teeth or area (50 mm x 37 mm): (Available on CD only.)

_____

_____

Panoramic Only

❑ Please perform digital panoramic radiograph:

Send by: ❑ CD ❑ Printed ❑ Office email on file ❑ Other email: _____

_____

_____

Signature and Acknowledgement

Robert W. Heydrich, DMD, MS and Andrew A. Jattan, DMD, MS individually, and on behalf of Edgewater Endodontics, LLC ("LLC") will have the requested images read by a medical or dental radiologist whose report will be forwarded directly to me, the referring doctor. I understand that Drs. Heydrich and Jattan's involvement in connection with this referral is limited to performing the study. Drs. Heydrich and Jattan, and employees of the LLC 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 judgment. By executing this referral form, I understand, acknowledge and accept the responsibility that as the referring doctor 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, and I further agree to protect, defend, indemnify and hold Drs. Heydrich and Jattan and the LLC completely harmless in discharging those responsibilities to the patient.

_____ _____

Referring Doctor Signature / Print Name *Date*

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