PLEASE BRING THIS REFERRAL FORM WITH YOU ON THE DAY OF YOUR APPOINTMENT.

AdvancedHead&Neck IMAGING CENTER

2860 Snelling Avenue North, Suite #2
Roseville, Minnesota 55113
Phone: 651.636.3050

www.headandneckimaging.com
info@headandneckimaging.com

Patient Name _____ Date of Birth _____ Phone _____

Address _____ City _____ State _____ Zip _____

Parent's Name (if minor) _____ Appointment Date _____

Maxillofacial CT Image CBCT (Conebeam CT) **Scan**

(please check below - arch or arches requested)

☐ Maxillary Arch ☐ Mandibular Arch ☐ Both Arches

***CT Scan will include a Radiologist Report unless box is checked below.**

☐ **NO Report Requested**

Patient is being referred for CT Imaging to aid in the diagnosis of:

❑ Implant(s) Implant Site # _____ ❑ Sinus Exam ❑ Reconstruction ❑ Oral Pathology

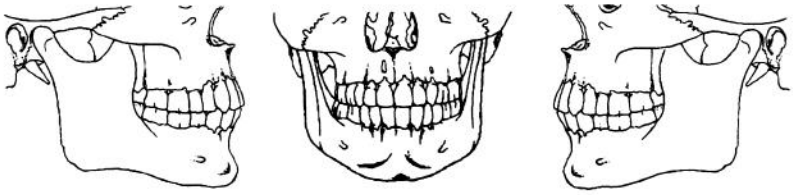
❑ Airway Evaluation ❑ TMJ Exam ❑ Dental Impaction ❑ Endodontics

***Reason for Exam (ICD-10 Code):** _____

ICD-10 Codes

K0820	Unspecified atrophy of edentulous alveolar ridge
K011	Disturbances in tooth eruption (Impacted teeth)
J329	Unspecified chronic sinusitis
M2660	TMJ unspecified
M272	Inflammatory conditions of jaws (i.e. Abcess, Osteomyelitis)
K001	Supernumerary teeth
K090	Developmental odontogenic cysts
K048	Radicular cyst (apical, periapical)
R209	Unspecified disturbances of skin sensation
M2619	Unspecified Anomaly

Please Circle the Region of Interest



Comments: _____

Images will be returned to referring doctor in the CD format, including viewing software.

CD is to be mailed (please print address) _____

Doctor (please print name) _____

Doctor Email (please print email address) _____

PAYMENT IS DUE WHEN SERVICES ARE RENDERED. WE DO NOT ACCEPT ASSIGNMENT OF INSURANCE.

UPON REQUEST FORMS WILL BE PROVIDED FOR POSSIBLE REIMBURSEMENT FROM YOUR INSURANCE CARRIER.

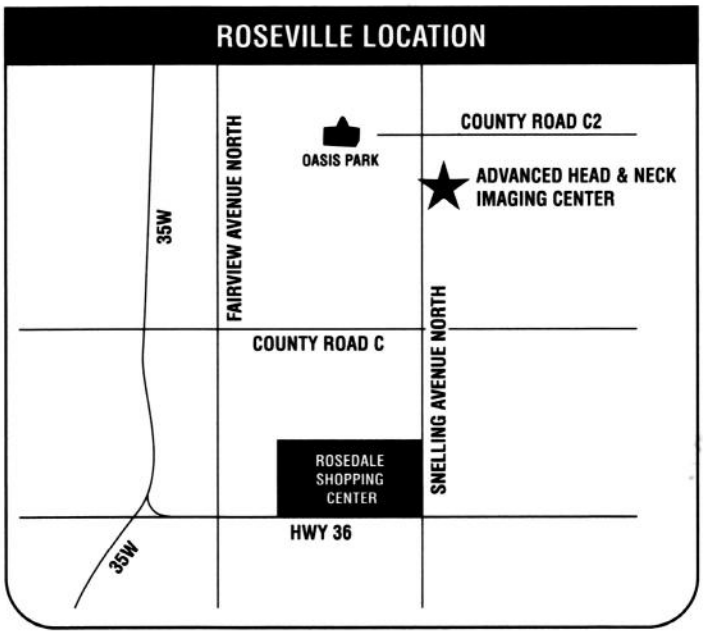
CONTACT YOUR CARRIER FOR COVERAGE INFORMATION.

Fee Pd ☐ Cash ☐ CC
Date _____
Provider _____

$ _____ FEE DUE AT TIME OF SERVICE

(If left blank please call for fee: **651.636.3050**)

ROSEVILLE LOCATION



2860 Snelling Avenue North, Suite #2
Roseville, Minnesota 55113
Phone: 651.636.3050

PATIENT INFORMATION

APPOINTMENTS
Please give a 24 hour notice if you need to change our appointment.

If you are late 15 minutes or more, it may be necessary to reschedule your appointment.

All images are delivered to the referring doctor unless prior arrangements have been made.

INSURANCE
Fees for images are payable at the time of your appointment. You will be provided with the necessary information for possible reimbursement from your insurance carrier. Contact your carrier for coverage information.

PREGNANCY
If you are pregnant, or think you may be pregnant, contact your physician before scheduling your appointment.

www.headandneckimaging.com **info@headandneckimaging.com**