TEXAS A&M UNIVERSITY
College of Dentistry

ORAL AND MAXILLOFACIAL IMAGING CENTER

214-828-8479 FAX: 214-874-4557

Name: _____ Date: ____/____/____

Address: _____ Date of Birth: ____/____/____

_____ Phone: _____

Doctor: _____

Address: _____ Phone: _____

_____ ☐ CASH

INSTRUCTIONS: ☐ Send to referring doctor ☐ Send with patient

☐ PANORAMIC

☐ Intraoral: FMX ____ Periapical _____ Bitewing ____

☐ Cephalometric: Lateral _____ Posteroanterior _____

☐ Other: _____

☐ J Morita - Accuitoma - Limited - Full

☐ I CAT - Flex - Full

☐ CONE-BEAM COMPUTED TOMOGRAPHY (CBCT)

☐ TMJ ☐ Implants Sites _____

☐ Other: _____

DIAGNOSTIC OBJECTIVE:

_____

_____

REFERRING DOCTOR: _____
signature and printed name

DO NOT WRITE BELOW THIS LINE - FOR RADIOLOGISTS ONLY

RADIOGRAPHIC IMPRESSION:

☐ Grossly Normal Study ☐ Findings ☐ Report to follow Date _____

RADIOLOGIST: _____

☐ M.K. Nair, DMD, MS, Phd ☐ Dr. Tahmasbi, DDS ☐ H. Liang, DDS, PhD, MS

Form 901AB Rev. 01/20

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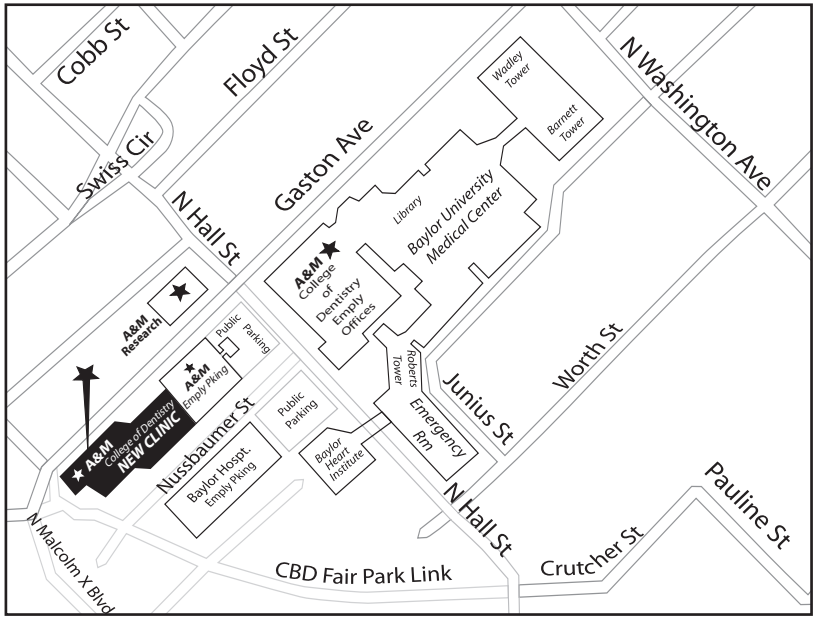

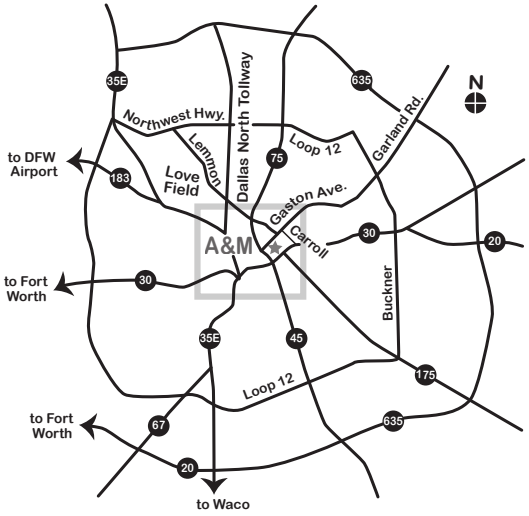

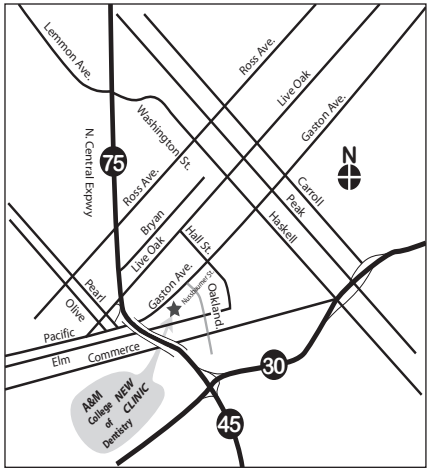

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