Aesthetic Dental Group

1555 West Broadway, Vancouver V6J 1W6 TEL: 604-738-3803 FAX: 604-738-3806
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Request for Consultation or Diagnostic Services

Patient's Name: ___________________________________ Date of Birth(MM/DD/YYYY): _______________________

Patient's Tel: _______________________________

Referring Doctor: ____ Office Tel: ________________________________

Insurance Carrier: ____

Policy Group #: ____________________________ Certificate ID #: ____

Diagnostic services:

- ☐ 3D CBCT (single – maxillary / mandibular **or** both arches)
- ☐ Panoramic Radiograph

Reason for Scan:

☐ Implant(s)/Graft (IAN Mapping) ☐ Orthodontic ☐ Sinus/Airway ☐ Endodontic

☐Wisdom Tooth Exo Extraction (IAN Mapping) ☐ Others : ____

Special Instructions: ____

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Signature of Referring Doctor: __________________________________

- ☐ Please call Patient
- ☐ Patient will call you