Hood River Imaging

CBCT REFERRAL FORM

PLEASE PRINT CLEARLY

Is this appointment urgent? Yes ☐ No ☐

First Name: _____________ Last Name: ___________________ DOB: _______ Sex: ____

Daytime Phone: ___________________ Message/Work Phone: ________________

Referring Doctor: ___________________ Referring Doctor Phone: _______________

Reason for exam: ____

Data Options: Raw Data Data and Viewing Software Included

Delivery Options: Mail CD to Doctor Hand carry CD by patient

Payment is due at the time of service. You may make arrangements with your provider's office to bill insurance for this service.