WesternU Health The Dental Center
795 E Second St, Suite 8
Pomona, CA 91766-2007
T: 909.706.3910 F: 909.469.8650

Radiology Referral

Please complete this form and fax it to 909.469.8650. Please contact The Dental Center for an appointment at 909.706.3910. We must have this form BEFORE we can schedule an appointment. Payment is due at the time services are rendered and range from $50 to $550 depending on the requested imaging.

PATIENT INFORMATION

Patient's Name *(Please print)*

Patient Date of Birth

Patient Primary Telephone/Mobile Number

Other Telephone/Mobile Number

REFERRING DOCTOR

Doctor's Name *(Please print)*

Practice Name

Address

City State Zip

Telephone Fax

Email

REQUESTED IMAGING SURVEY

Indicate Request Imaging: (Check ALL that apply)

- ☐ Lateral Cephalometric
- ☐ Panoramic
- ☐ Full Mouth Series

CONE BEAM COMPUTED TOMOGRAPHY (CBCT)

- ☐ D0364 less than 1 whole jaw w/ report -$250
- ☐ D0365 -mandible w/report $350
- ☐ D0366 -maxilla w/report $350
- ☐ D0367 -both jaws w/report $550
- ☐ D0368 -TMJ series w/report $350
- ☐ D0380 - limited field of view-< 1 jaw no report $150
- ☐ D0381 -dental arch mandible no report $200
- ☐ D0382 -dental arch maxilla no report $200
- ☐ D0383 -/field of view-both jaws no report $400
- ☐ D0384 – TMJ series 2 or more exposures $300
- ☐ D0391 –Interpretation of diagnostic image including report $150

Please Specify Site: _____

Relevant Clinical Findings and Special Instructions:

DOCTOR SIGNATURE, DATE AND FAX REQUIRED

Dr. _____

Date: _____

Fax: _____