Dear Doctor,

Thank you for referring your patient to OHSU School of Dentistry for a Cone Beam CT scan and interpretation. The following attached forms need to be completed so that we may schedule your patient for the procedure:

**Cone Beam CT Imaging Request:** Please complete this order in its entirety. This request serves as your written prescription for the imaging and provides the radiology clinic information as to the reason for the scan and area to be imaged.

**Patient Information and Acknowledgment for Cone Beam CT Imaging:** This form provides information on the scan procedure that you must review with your patient. Please have your patient sign and date the bottom of the form. You (doctor) also must sign and date the form.

**Patient Information form:** This is information we need to register the patient as a “limited care patient” at Oregon Health & Science University School of Dentistry. The patient must be registered before an appointment can be scheduled.

**Screening Patient Medical History:** This must be filled out in its entirety. If this is filled out from the information on your office’s medical history, you must sign as “patient’s representative” and “relationship to patient” would be dentist or physician.

Please fill out all forms and FAX to 503-346-8121 or email a scanned copy to sodrad@ohsu.edu

The fee for the scan is $199.00 for a single jaw (maxilla or mandible, 5x5 cm or 5x10 cm field of view scans) and $299.00 for a full scan which cover both jaw (10x10 cm or 17x13.5 cm field of view scans). The scan will include a written radiographic interpretation signed by one of our Board-certified Oral and Maxillofacial Radiologists. The report will not be available immediately and arrangements will be made to get the report to the ordering dentist. The CBCT dataset can be available immediately (released to patient on day of scan) or mailed to office per instructions on the detailed request for cone beam CT Imaging.

The procedure requires the patient to be alert, sitting upright and still for 30 seconds. If for some reason the patient is not able to comply with these requirements, the procedure will not be performed. The radiology clinic may determine this procedure will not be safe for the patient as the machine revolves quickly around the patient’s head and shoulders several times.

Please contact us should you have any questions or if we may be of any assistance regarding the Cone Beam CT scan.
# Cone Beam CT Imaging Request

<table>
<thead>
<tr>
<th>Patient:</th>
<th>Sex: M / F</th>
<th>Date of birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor:</td>
<td>Email:</td>
<td></td>
</tr>
<tr>
<td>Practice:</td>
<td>Phone:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td>State:</td>
<td>Zip code:</td>
</tr>
</tbody>
</table>

### Reason for exam: (check all that apply)
- [ ] Implant planning
- [ ] Tooth extraction
- [ ] TMJ
- [ ] Bone graft
- [ ] 3rd molar
- [ ] Paranasal sinuses
- [ ] Pathology
- [ ] Impacted tooth
- [ ] Endodontics
- [ ] Other:

### Tooth/Area:

### Relevant history:

### Surgical guide:
- [ ] No
- [ ] Yes (Patient must bring guide to appointment and know how to place themselves, radiology staff will not place guides)

### Volume size (Select one)

<table>
<thead>
<tr>
<th>Volume size</th>
<th>Price</th>
<th>Area to be scanned</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>5x5cm</td>
<td>$199</td>
<td>Single quadrant</td>
<td>Limited field of view (2 adjacent teeth) Standard resolution</td>
</tr>
<tr>
<td>5x5cm endo mode</td>
<td>$199</td>
<td>Single quadrant</td>
<td>Limited field of view (2 adjacent teeth) High resolution</td>
</tr>
<tr>
<td>10x5cm</td>
<td>$199</td>
<td>One jaw</td>
<td>Second molar to second molar visualized NOT indicated for 3rd molar evaluation</td>
</tr>
<tr>
<td>10x10cm</td>
<td>$299</td>
<td>Both jaws</td>
<td>3rd molars may not be depicted NOT indicated for TMJ evaluation</td>
</tr>
<tr>
<td>17x13cm</td>
<td>$299</td>
<td>Full scan</td>
<td>Large field of view Indicated for 3rd molar and/or TMJ evaluation</td>
</tr>
</tbody>
</table>

### Scan delivery method:
- [ ] Give to patient at appointment
- [ ] USPS mail

### Report delivery method:
- [ ] Secure E-Mail (PDF version)
- [ ] USPS mail (printed copy)

**Signature of Doctor:** ___________________________  **Date:** ___________________________
PATIENT INFORMATION AND ACKNOWLEDGMENT FOR CONE BEAM CT IMAGING

I authorize OHSU School of Dentistry Oral Radiology Clinic staff to make a Cone Beam Computed Tomography (CBCT) scan of my jaw(s) for dental purposes.

CBCT machines use x rays to acquire the scans. The CBCT machine at the OHSU School of Dentistry is a type of scanner that uses much less radiation than most medical CT machines used in hospitals. The CBCT machine at OHSU uses slightly more radiation than conventional (including digital) dental imaging.

The images produced by this scan reveal far more structures than those visible in typical dental radiographs. I understand that this scan is being used only for dental treatment planning. Some abnormalities or diseases that might be visible in some of the scan images may need to be addressed by other healthcare providers referred by my dentist.

I certify that I have had an opportunity to read and that I fully understand the terms within the above consent. Procedures, alternatives, risks and questions have been discussed and answered to my satisfaction.

Patient Signature: ____________________________ Date: ________________

Parent or Guardian: ____________________________ Date: ________________

Doctor Signature: ____________________________ Date: ________________
**WELCOME TO OHSU DENTAL CLINICS**

So we may serve you better, please complete all portions of this patient information form.

**Patient's name:** 

(First)  (Middle)  (Last)

**Sex:**  □ Male  □ Female  □ Transgender: preferred pronoun ________________________

**Date of Birth:** __/__/____  **Social Security Number (SSN):** _______ - _____ - _______

**Home Address:** 

(Street)  (Apt #)  (City)  (State)  (Zip Code)

**Mailing Address (if different):** 

(Street)  (Apt #)  (City)  (State)  (Zip Code)

**Primary Phone:** (_____)-_________  **Cell**  **Home**  **Work** (please circle)

**Secondary Phone:** (_____)-_________  **Cell**  **Home**  **Work** (please circle)

**Email Address:** ____________________________

**How would you prefer to be contacted?** Check all that apply:  □ Phone  □ Text  □ Email

**In case of emergency, please notify:** 

(First)  (Last)

**Phone:** (_____)-______-______  **Relationship** ________________________________

**How did you hear about us?** ________________________________

**Marital Status:**  □ Single  □ Married  □ Partnered  □ Divorced  □ Widowed

**Do you require a language interpreter?**  □ No  □ Yes  **Which language:** ____________________________

**Do you have any special needs/accommodations?**  □ Yes  □ No

**If yes, what is your need?**  □ Blind/Visually Impaired  □ Deaf/Hearing Impaired  □ Wheelchair

**Race (Select ALL groups with who you identify):**  □ American Indian or Alaska Native  □ Asian

□ Black or African American  □ White  □ Native Hawaiian or other Pacific Islander

**Ethnic Category:**  □ Hispanic or Latino  □ Not Hispanic or Latino  □ Other

**Do you have dental insurance or any program which will cover dental expenses?**  □ Yes  □ No

If yes, insurance must be verified by Managed Care before scheduling.

Please contact Managed Care at 503-346-4630 or sodmanagedcare@ohsu.edu
SCREENING PATIENT MEDICAL HISTORY

Date: ______________________

Patient Name: ______________________ Age: ________

Chief Dental Concern: ______________________

<table>
<thead>
<tr>
<th>Condition</th>
<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
<td>Heart Condition</td>
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<tr>
<td>Heart Surgery</td>
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<tr>
<td>Heart Valve Replacement</td>
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<tr>
<td>Stroke</td>
<td></td>
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<tr>
<td>High Blood Pressure</td>
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<tr>
<td>Bleeding Disorder</td>
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<tr>
<td>Asthma/Lung/Respiratory Conditions</td>
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<td></td>
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<tr>
<td>Cancer or other tumor</td>
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<tr>
<td>Diabetes</td>
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<tr>
<td>Tuberculosis</td>
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<tr>
<td>Kidney/Renal Disease</td>
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<tr>
<td>Hepatitis/Liver Disease</td>
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<tr>
<td>HIV/AIDS</td>
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<tr>
<td>Epilepsy/Seizures</td>
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<tr>
<td>Joint Replacement</td>
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<td></td>
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<tr>
<td>Organ Transplant</td>
<td></td>
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</tbody>
</table>

Have you had or have you ever experienced any of the following conditions? (Circle “YES” or “NO” to all questions)

1. Are you under the care of a physician at the present time or have you been treated by a physician in the past six months? If yes, for what condition? ____________

2. Are you taking any medications, pills, or drugs (prescribed or not)?
   If yes, please list: ____________________________________________________________________________

3. Are you allergic to any medicines, drugs, latex, or other things?
   If yes, please list: ____________________________________________________________________________

4. Have you ever received intravenous bisphosphonates (e.g. Zometa, Aredia) for bone cancer or severe osteoporosis?

5. Do you have any disease, condition or problem not listed above of which we should be aware?
   If yes, please list: ____________________________________________________________________________

6. Are you pregnant?
   If yes, expected due date: ______________

Patient Signature: ______________________ Date: __________
(or) Patient’s representative: __________________________ Relationship to patient: ________

NOTE: If the patient is not admitted for treatment, this Screening Medical History form is destroyed. If the patient is admitted, a comprehensive medical history must be completed (some of the above questions may be repeated).