School of DENTISTRY
Oral & Maxillofacial Radiology

Oral Radiology Clinic
Imaging Services
Ph. 503-494-8930
sodrad@ohsu.edu

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.

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Cone Beam CT Imaging Request

Patient:		**Sex:** M / F	**Date of birth:**
Doctor:			**Email:**
Practice:			**Phone:**
Address:		**State:**	**Zip code:**
Reason for exam: (check all that apply)	____ Implant planning ____ Bone graft ____ Pathology ____ Other:	____ Tooth extraction ____ 3rd molar ____ Impacted tooth	____ TMJ ____ Paranasal sinuses ____ Endodontics
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)*	**Price**	**Area to be scanned**	**Notes**
_____ 5x5cm	$199	Single quadrant	Limited field of view (2 adjacent teeth) Standard resolution
_____ 5x5cm endo mode	$199	Single quadrant	Limited field of view (2 adjacent teeth) High resolution
_____ 10x5cm	$199	One jaw	Second molar to second molar visualized NOT indicated for 3rd molar evaluation
_____ 10x10cm	$299	Both jaws	3rd molars may not be depicted NOT indicated for TMJ evaluation
_____ 17x13cm	$299	Full scan	Large field of view Indicated for 3rd molar and/or TMJ evaluation

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:** _____

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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:** _____

School of DENTISTRY

OHSU

WELCOME TO OHSU DENTAL CLINICS

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

Patient's name: _____
(Last) (First) (Middle)

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: _____
(Last) (First)

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: _____

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

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

Please answer the following questions as completely and accurately as possible:

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?_____ YES NO

2. Are you taking any medications, pills, or drugs (prescribed or not)? YES NO
   If yes, please list: _____

3. Are you allergic to any medicines, drugs, latex, or other things? YES NO
   If yes, please list: _____

4. Have you ever received intravenous bisphosphonates (e.g. Zometa, Aredia) for bone cancer or severe osteoporosis? YES NO

5. Do you have any disease, condition or problem not listed above of which we should be aware? YES NO
   If yes, please list:_____

6. Are you pregnant? YES NO
   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).