



DENTAL IMAGING REQUEST

Patient Details

Last Name: _____ Gender: M F

First Name: _____ Contact Number Mobile: _____

Street Address: _____ Medicare: _____

Address Line 2: _____ Ref: _____

Suburb: _____ Exp Date: _____ / /

State/Postalcode: _____

Procedure requested

<p>Dental and Maxillofacial Imaging:</p> <p><input type="checkbox"/> X-ray Orthopantomogram</p> <p><input type="checkbox"/> X-ray TMJs</p> <p><input type="checkbox"/> CBCT Both Arches + Airway Analysis</p> <p><input type="checkbox"/> CBCT Both Arches</p> <p><input type="checkbox"/> CBCT Maxilla</p> <p><input type="checkbox"/> CBCT Mandible</p> <p><input type="checkbox"/> CBCT TMJs</p>	<p>Cranial and Cephalometric Imaging:</p> <p><input type="checkbox"/> X-ray Skull</p> <p><input type="checkbox"/> X-ray Lateral Cephalometry</p> <p><input type="checkbox"/> X-ray Frontal Cephalometry</p> <p><input type="checkbox"/> CBCT Airway Analysis</p> <p>Sinus Imaging:</p> <p><input type="checkbox"/> X-ray Sinuses</p> <p><input type="checkbox"/> CBCT Sinuses</p>	<p>Face scanning:</p> <p><input type="checkbox"/> Face Scan</p> <p>Intraoral (coming in 2025)</p> <p><input type="checkbox"/> Intraoral Scan</p>
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Area of interest

Right								Left							
18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38

Clinical Notes

Referrer Details

Referrer Name: _____ Provider No: _____

E-mail: _____ Telephone: _____

Address: _____ Clinic: _____

Postalcode: _____

Date: _____ / / Signature: _____

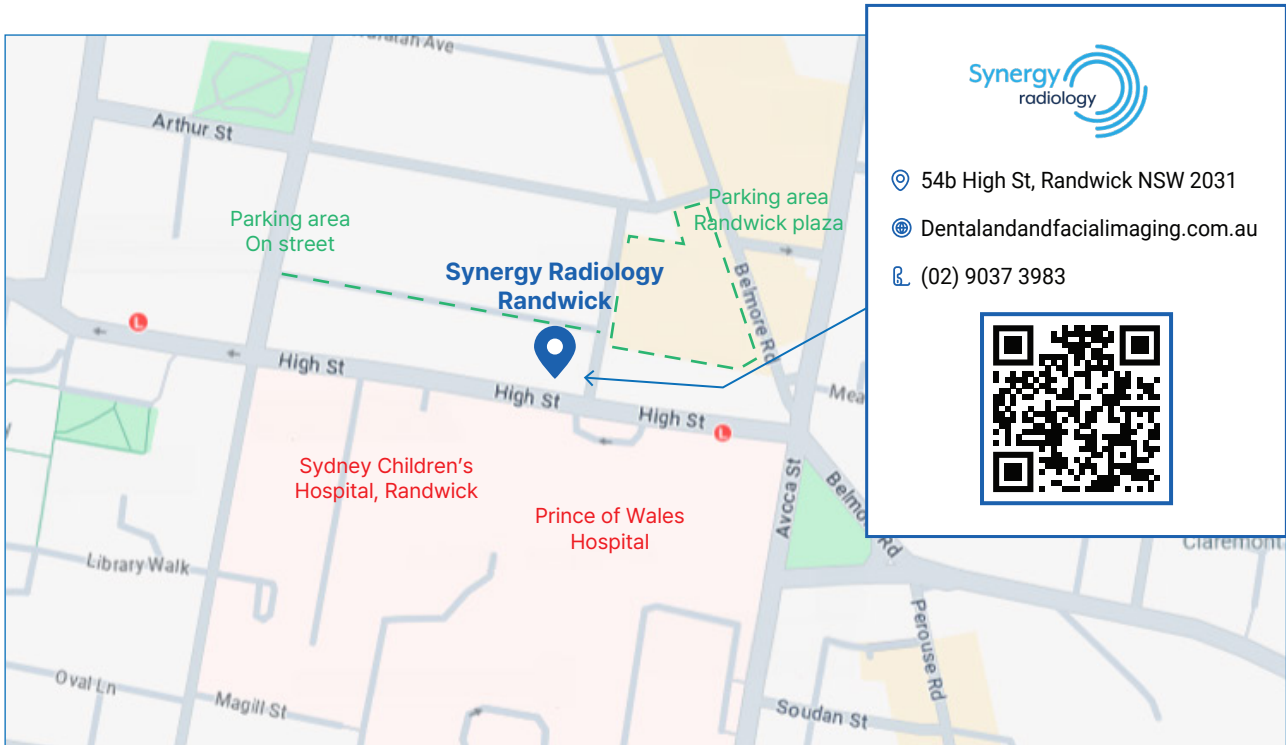
Your dentist has recommended that you use Dental and Facial Imaging Centre. You may choose another provider but please discuss that with your doctor first.



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Location

- The Dental and Facial Imaging Center is located **inside the Synergy Radiology Randwick practice**.
- Parking spots available on Blenheim St (on the street) and inside the Randwick Plaza parking area.



No need to call for an appointment. Simply visit our center, and we will happily assist you. It's quick and easy!