MAHEC

Dental Health Center and Center for Advanced Training

CBCT/3D IMAGING REFERRAL FORM

PATIENT INFORMATION

Name: DOB: Male: ☐ Female: ☐

Address: City:

State: Zip Code: Telephone: Email:

Today's Date: Appointment Date/Time: Consult Date:

REFERRING DOCTOR

Name: Address:

Telephone: Email:

SPECIFY EXAM

☐ DO381 Full Arch Mandible
☐ DO382 Full Arch Maxilla
☐ DO380 Limited Field; Specify Area
☐ DO383 Both Arches

SPECIAL INSTRUCTIONS

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MAHEC Dental Health Center and Center for Advanced Training
123 Hendersonville Road
Asheville, NC 28803
828-252-4290

MAHEC Dental Health Center at Columbus
130 Forest Glen Road
Columbus, NC 28722
828-722-0003