ardentis
CLINIQUES DENTAIRES

CONE BEAM COMPUTED TOMOGRAPHY (CBCT) REQUEST FORM

PATIENT INFORMATION : *(write in capital letters)*

Ms., Miss, Mr. Last Name ..... First Name .....

Date of Birth .....

REFERRING DENTIST :

Dentist's Name .....

Adress ..... Postal Code ..... City .....

Region(s) to be Examined :

.....

.....

.....

Remarks :

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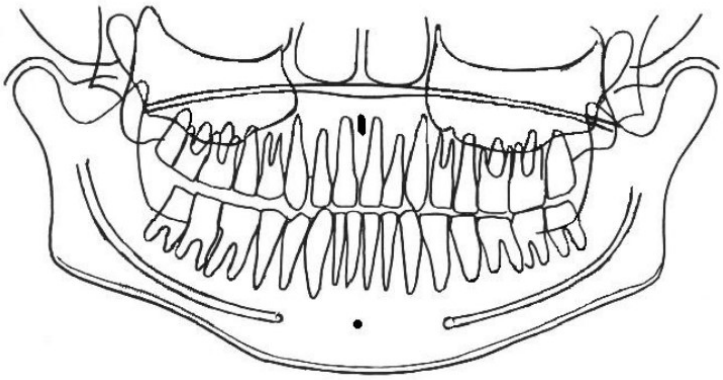

PLEASE CIRCLE THE REGION(S) TO BE EXAMINED.

ARDENTIS CLINIC

☐ ***No preference*** ☐ Lausanne Flon ☐ Sion ☐ Vevey

☐ Morges ☐ Neuchâtel ☐ Martigny ☐ Yverdon

- This request must be completed by your dentist and submitted to the clinic reception.
- If applicable, please bring the radiographic image provided by your dentist *(a copy of an intraoral or panoramic X-ray)*.
- The examination fee must be paid at the end of the appointment.
- For ARDENTIS group patients: tomographic examinations will be transmitted via our computer network and placed directly in your file. A copy of the file will remain saved on our computer server.

- I authorize ARDENTIS to send my documents via swisstransfer after the examination.

Date ..... Signature & Stamp of the Referring Dentist .....