

DENTAL IMAGING REQUEST



Our rooms are located at -
257 Fullarton Road, Parkside SA 5063

Date _____

Time _____

Ph 08 8357 8855

PLEASE BRING THIS REQUEST FORM, YOUR MEDICARE CARD, PENSION AND HEALTHCARE CARDS AND ALL PREVIOUS FILMS WITH YOU.

PATIENT DETAILS

Name _____

Address _____

Date of Birth _____

Telephone (H) _____

Telephone (M) _____

Medicare Number _____

ID Check

EXAMINATION REQUESTED

OPG	<input type="checkbox"/>	Region of Interest																	
Cephalostat	<input type="checkbox"/>	18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28		
Bone Age	<input type="checkbox"/>	_____																	
TMJ	<input type="checkbox"/>	48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38		
CT	<input type="checkbox"/>	_____																	

CLINICAL DETAILS

REFERRING DOCTOR DETAILS

Doctor's Name (Printed) _____

Date _____

Provider No. _____

Doctor's Signature _____

Entrance and exit off Hone Street from Fullarton Road.

Monday - Friday
8.30am - 5.00pm
Closed Public Holidays