RADIOGRAPH INTERPRETATION

Patient's Name and Address

Oral and Maxillofacial Radiology
University of Florida
PO Box 100414
Gainesville, FL 32610-0414
Phone: (352) 273-6775

Date of Birth | Exam Date | Sex: M / F / O

Send completed form to either:

Referring Doctor's Name and Address

Fax: (352) 273-6553
Email: OralRad@dental.ufl.edu

Type of Practice

- ☐ GP
- ☐ Endo
- ☐ ENT
- ☐ OS
- ☐ Ortho
- ☐ Pedo
- ☐ Perio
- ☐ Other

Type of Study - *Please check all applicable*

- ☐ STAT / same-day
- ☐ Full Mouth Series
- ☐ Periapical
- ☐ Addon: Pantomograph
- ☐ CBCT
- ☐ Pantomograph
- ☐ TMJ MRI
- ☐ Add-on: Periapical

Phone Number | Fax Number | E-mail

TO BE COMPLETED BY REFERRING DOCTOR

Pertinent History

Signs, Symptoms, and Relevant Diagnosis

Specific question(s) to be answered by this study

Is patient pregnant? Y / N / Not Applicable

Referring Doctor's Signature/Affirmation