

U of M Maxillofacial Imaging Clinic

7-238 Malcolm Moos Health Sciences Tower
515 Delaware Street S.E., Minneapolis, MN 55455
Appt. Phone: 612-624-6061 Appt. Fax: 612-625-5758
Consult Phone: 612-625-6147 (Dr. Ahmad)



UNIVERSITY OF MINNESOTA

Last: _____ First: _____ Middle Initial _____ Gender: M F

Home # (_____) _____ Work # (_____) _____ DOB: ____/____/____

Street: _____ Apt # _____

City: _____ State: _____ Zip: _____ U of M Chart #: _____

Insurance Information (please bring all insurance information to your appointment)

Group Number: _____ MEDICA UCare Other: _____
ID number: _____ Health Partners Preferred One
 Blue Cross Blue Shield MEDICARE

Area(s) of scan:

Maxillary arch only Mandibular arch only Closed Mouth (includes both arches and TMJs)
 Both arches (for implants) Orthodontic scan (orbits to chin) Open Mouth (TMJ areas only)

Required Information:

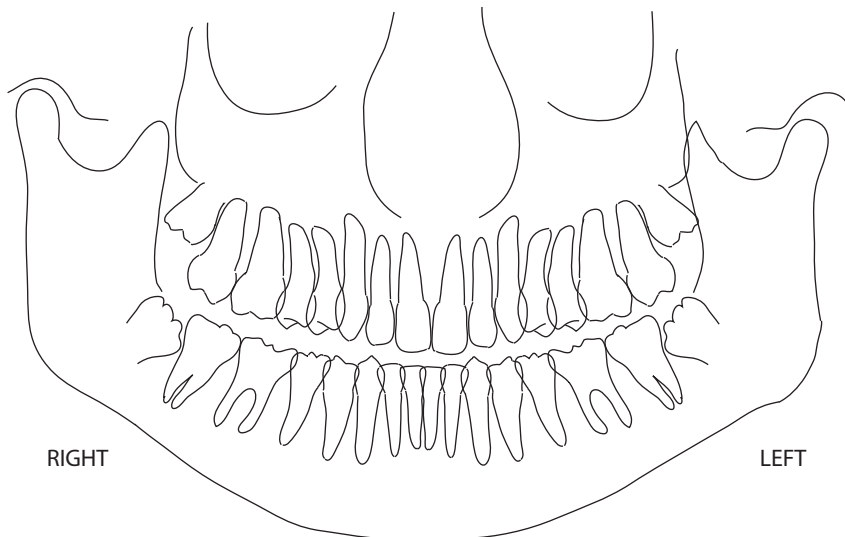
For Medical imaging, list all ICD 9 codes including any aftercare "V" codes : _____

1. Provisional Diagnosis: _____

2. Previous treatment /imaging Yes No. Please specify: _____

3. Clinical indications for imaging (Describe signs, symptoms or provide information to support medical necessity) _____

Indicate area(s) of interest on the image below



For Maxillofacial Imaging Clinic use only

Appointment Day and Date:

Appointment Time: _____
(Parent or legal guardian must accompany minors)

RT _____

RT comments: _____

Pregnant: Yes No

DOI _____

Radiologist _____

Referring Doctor (please PRINT full name): _____ Signature _____

Phone: (_____) _____ - _____ Fax: (_____) _____ - _____ Date of order ____/____/____

Referring Clinic: _____ Street: _____

City: _____ State: _____ Zip: _____ If U of M Clinic (floor/location): _____

Results: Check all that apply: CD Prints on paper Send copy with patient Read and call ASAP: Tel _____