U of M Maxillofacial Imaging Clinic

7-238 Malcolm Moos Health Sciences Tower
515 Delaware Street S.E., Minneapolis, MN 55455
Appt. Phone: 612-625-2495 Appt. Fax: 612-625-5758

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: ______________________

ID number: ______________________

❑ MEDICA
❑ Health Partners
❑ Blue Cross Blue Shield
❑ UCare
❑ Preferred One
❑ MEDICARE
❑ Other: ______________________

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:

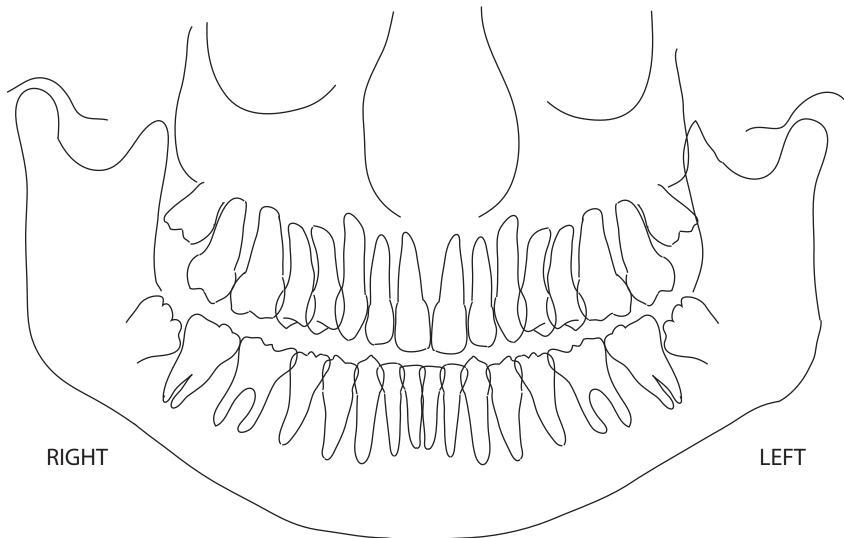
For Medical imaging, list all ICD 10 codes including any aftercare "V" codes : ______________________

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 ______________________

Sept 2019