Orthopantomogram (OPG) Request Form

Referring Dentist

Dentist Name:

Date Sent:

Practice name:

Practice address:

Postcode:

Practice Telephone:

Practice Email:

Patient Details

Title/Name:

Date of Birth:

Address:

Postcode:

Telephone/Mobile Number:

Email:

Preferred Contact Method:

Medical History:

Finedon Dental Practice 2, Tann Road, Finedon, Northamptonshire. NN9 5JA
Email: information@finedondentalpractice.co.uk

FINEDON DENTAL PRACTICE

OPG Justification

Implant treatment planning	☐	TMJ	☐
Orthodontic Assessment & Planning	☐	Endodontic Assessment	☐
Impacted Teeth Assessment	☐	Other (please specify)	☐

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OPG Charges

OPG	£60.00

YOUR PATIENT WILL BE ASKED TO PAY FOR THEIR SCAN AT THE APPOINTMENT UNLESS YOU INSTRUCT US OTHERWISE.

Patient informed of approximate cost

☐

I hereby authorise Finedon Dental Practice to carry out an OPG on my behalf. The results of the radiograph will be returned via email. I am responsible for assessing the data and referring to the necessary specialties as clinically indicated. Finedon Dental Practice and the operator will not be responsible for assessing the OPG for the suitability of treatment of for immediately identifying and referring pathology; by referring this patient I am accepting this responsibility. I certify that I have obtained the necessary qualifications in order to refer and evaluate the data requested by me and provided by Finedon Dental Practice. I have obtained consent from the patient to share their personal data via non-encrypted email, in line with GDPR data security.

Referring Dentist Name ………………………………………………………………………….

Dentist signature …………………………………………… GDC Number ……………………….