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## INFORMED CONSENT FOR DENTAL CBCT SCAN

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Patient's Name \_\_\_\_\_

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Date of Birth \_\_\_\_\_

**CBCT scan:** Also known as a cone beam computerized tomography, is an x-ray technique that produces 3D images of your skull, allowing for visualization of internal body bony structures in cross section. CBCT scans are primarily used in endodontics to visualize the internal root canal anatomy.

**Advantages of CBCT scan over conventional x-rays:** A conventional x-ray of your mouth limits your dentist to a 2D visualization. Diagnosis and treatment planning can require a more complete understanding of complex three-dimensional or 3D anatomy. CBCT examinations provide a wealth of information which will be used when performing any endodontic treatment.

**Benefits of CBCT scan include:** Visualization of vital structures such as nerves and sinus cavities. Greater chance for diagnosis of conditions such as vertical root fractures that can be missed on conventional x-ray films. Greater chance of providing images and information which may result in the patient avoiding unnecessary dental treatment. The CBCT scan enhances your dentist's ability to see what needs to be done before your treatment is started.

**Radiation:** CBCT scans, like conventional x-rays, expose you to radiation. The amount of radiation used for CBCT examinations is carefully controlled to ensure the smallest possible amount is used that will still give a useful result. The dosage per scan is equivalent to a full mouth series of x-rays AKA new patient x-rays.

**Pregnancy:** Women who are pregnant SHOULD NOT undergo a CBCT scan due to the potential exposure to the fetus. Please tell your doctor if you are pregnant or planning to become pregnant.

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**Diagnosis of non-dental conditions:** While parts of your anatomy beyond your mouth and jaw may be visualized in the scan, your doctor may not be qualified to diagnose conditions that may be present in the head and neck beyond the dental zone. A CBCT may show evidence of disease of the cervical spine, skull, or arteries. If any abnormalities, asymmetries, or common pathological conditions are noted upon the CBCT scan, it may become necessary to send the scan to a maxillofacial radiologist for further diagnosis. However, by signing this form, you are acknowledging that your doctor may not be qualified to diagnose all conditions that may be present, and that his/her liability only extends to the limits of the dental purpose of the scan and its interpretation for that purpose. We are not responsible for interpretation or evaluation of the scan, but are only providing the scan for the evaluation at our office.

**If you are interested in having a copy of your CBCT sent to a maxillofacial radiologist, please check the applicable section:**

- I want to have my CBCT scan read by a maxillofacial radiologist. I understand that I am responsible for the additional cost of \$160. This fee may not be covered by your dental insurance. You may be responsible you direct responsibility.
- I understand the benefits of having my CBCT scan read by a maxillofacial radiologist; however, I am knowingly declining such a referral.

\*Please note sending a copy of your CBCT to a maxillofacial radiologist may be medically required by the specialty team, and the fee of \$160 will be incurred. You will be informed at your appointment if a report is required.

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PLEASE DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT, UNDERSTAND IT AND AGREE TO ACCEPT THE RISKS AND ADVANTATGES NOTED.

I certify that I have read the above statement. I understand the procedure to be used and its benefits, risks, and alternatives. I have been given the opportunity to have my questions answered, and accept the risks of the CBCT scanning procedure as described. I therefore give my consent to have a CBCT scan performed.

Printed Name of Patient: \_\_\_\_\_

Signature of Patient: \_\_\_\_\_

Legal Guardian (if applicable): \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Requesting Doctor: \_\_\_\_\_