



Dr. Devin Croft DDS, MS

Diplomate Academy Clinical
Sleep Disorder Disciplines

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Date: _____ Referring Dentist: _____

Patients Name: _____ DOB: _____

Please Take: ☐ Panoramic X-ray
☐ Cone Beam (CBCT) Scan

☐ Radiographic Interpretation of CBCT to evaluate (additional fees apply)

*It is the responsibility of the ordering Doctor to obtain a radiographic interpretation unless requested.

☐ Pathology ☐ Implants ☐ Airway
☐ 3rd Molars ☐ TMJ ☐ Other

Upper Right

	A	B	C	D	E	F	G	H	I	J					
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
	T	S	R	Q	P	O	N	M	L	K					

Other Procedures & Remarks:
