



## Informed Consent for Dental CBCT Scan

A **CBCT Scan**, also known as a cone beam computerized tomography, is an x-ray technique that produces 3D (3 dimensional) images of your skull, allowing for visualization of internal body bony structures in cross section (rather than as overlapping images typically produced by conventional x-ray exams). CBCT scans are primarily used to visualize bony structures, such as teeth and your jaws, and not for soft tissues such as your tongue or gums.

**Advantages of CBCT Scan over conventional x-rays:**

A conventional x-ray of your mouth limits your dentist to a two-dimensional or 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 3D information which may be used when planning for dental implants, surgical extractions, maxillofacial surgery, and advanced dental restorative procedures.

**Benefits of CBCT Scan include:**

Visualization of vital structures such as nerves and sinus cavities. Higher accuracy in determining bone volume and bone density when planning implant surgery. Greater chance for diagnosis condition 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 2 regular dental x-rays: however, all radiation exposure is linked with a slightly higher risk of developing cancer. The advantages of the CBCT scan outweigh this disadvantage.

**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.

**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 \$100.
- I understand the benefits of having my CBCT scan read by a maxillofacial radiologist; however, I am knowingly declining such a referral.

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

I understand that IF I require a copy to be taken out of our office that I am responsible to pay a \$200 duplication and radiology report fee.

Printed Name of Patient: \_\_\_\_\_ Legal Guardian (if applicable): \_\_\_\_\_

Signature of Patient/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_