OPG Request Form

PRIORY DENTAL CARE

Patient Details

Title: First Name: Surname:

Address:

Postcode:

Date of Birth: Email:

Telephone: Mobile:

Referring Dentist Details

Dentist Name: GDC No:

Practice Address:

Postcode: Telephone:

Email:

Justification for OPG:

OPG Fee £65 *(as at 01/01/2026)*

☐ I understand that, as the referrer, I undertake to report on the radiograph, as per IR(ME)R 2017 requirements. As the referrer, I am also responsible for ensuring the clinical evaluation takes place and is properly recorded.

Referring Dentist Signature: Date: