PATIENT NAME _____ APPT. DATE_____

D.O.B_____ APPT. TIME_____

PHONE#_____ ☐ CHARGE PATIENT ☐ CHARGE OFFICE

ADDRESS _____ COST $_____

(Location where scan will be performed)

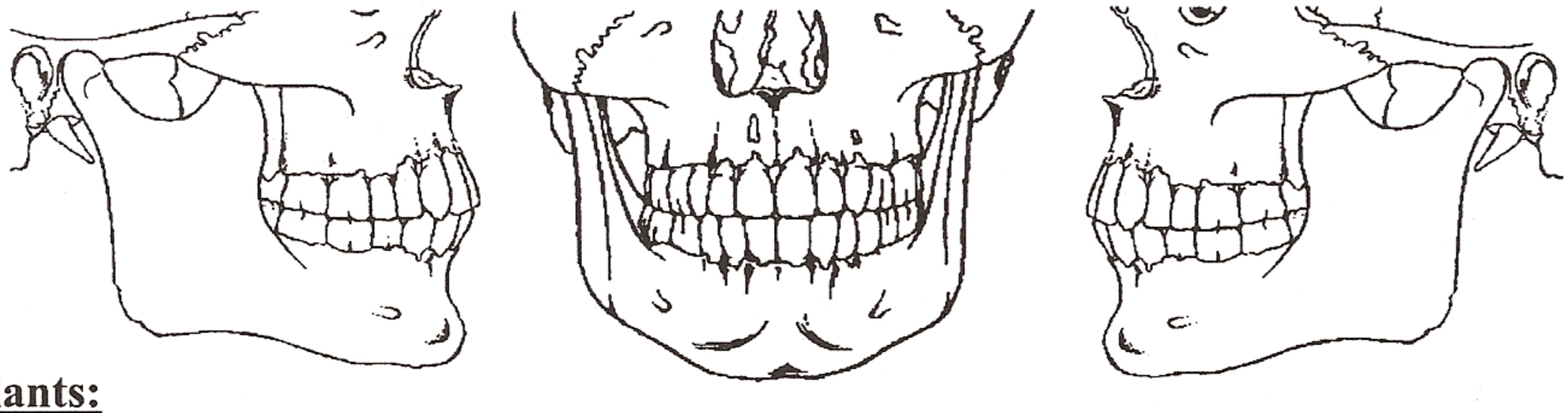
3-D CBCT Volumetric Imaging

☐ Implants ☐ Dental Impaction ☐ Airway Assessment ☐ Sinus Exam

☐ TMJ Exam ☐ Oral Pathology ☐ Endodontics ☐ Panoramic

☐ Other_____

Please circle the Region of Interest (ROI)



Implants:

Implant area: Mandible_____ Maxilla_____ Both _____

Is your patient coming with a radiographic template? Yes ☐ No ☐

(Indicate teeth or area of interest)

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

implant concierge™

(866) 977 2228

Dental 3D has partnered with Implant Concierge for Implant Planning / Radiology Reports.

Do you have an implant planing software? ☐Yes ☐No

If Yes specify:

_____

Preferred Reproduction Format

☐ CD ☐ Online

☐ Study

☐ Dicom

Special Instructions: _____

_____

_____

By signing below, I requested Dental 3D to acquire , review and in.terpret the images and Authorization from patient for these procedures. I understand there is a $50.00 same day Cancellation Fee if I do not cancel my appointment 24 hours before the scheduled date.

DATE _____

*Dr. (Print Name):*_____ *Address:*_____

*Phone#:*_____ *Fax#:*_____

*Signature:*_____ *Email Address:*_____