

OrthoDent **3D** Imaging

Patient: _____ DOB: _____ Ph # _____
Date of Referral: _____ Referred by: _____
Appointment Date/Time _____ Estimated Cost \$ _____

Implant/Restorative Studies

- 3D CBCT Scan (Raw DICOM data)
- Basic Formatting w/ Viewing Software
- Introductory Scan Package
(Pano, Limited Cross Sectional Analysis, and Viewing Software)
- Plus Scan Package
(Digital Photography Series, Cross Sectional Analysis, Pano, Viewing Software)
- Implant Planning Scan Package
- Surgical Guide Scan Package with CAD/CAM Guide
(Implant Planning and Surgical Guide Fabrication)
- 3rd Party Implant Planning Software Manipulation of CBCT Data

Implant Mandible *(specify site)* _____

Implant Maxilla *(specify site)* _____

Orthodontic/Surgical Studies/Photographic

- 3D CBCT scan *(Raw DICOM Data)*
- Ortho Records Package *(please specify)* _____
- All Digital CBCT Image formatting
 - Cephalometric *(Specify View – Lateral /PA)* _____
 - Panoramic
 - Sextant study *(includes ectopic eruption, ie. Impacted Maxillary Cuspids)*
Describe _____
 - Third molar study *(each)*
Specify _____
- Lateral Cephalometric tracing- *custom analysis available*
- Photographic series- *8 view, all digital (3 Extraoral and 5 Intraoral)*
- Invisalign Package- *(Photos and Pano)*

Hard copy printouts are available for any of the above digital representations

Please specify: _____

Special Studies

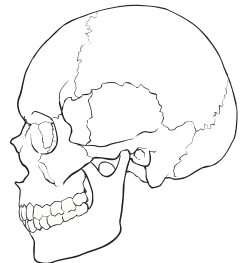
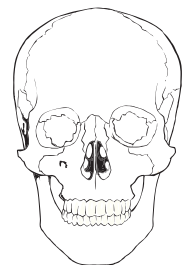
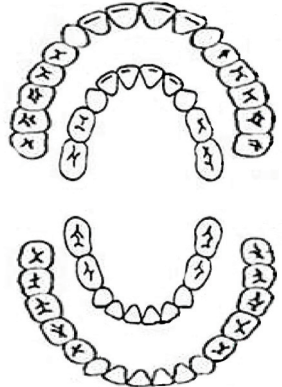
(Please check all that apply)

- TMJ Study *(includes left and right)* Sinus Assessment Airway Assessment
- Endodontic Study *(specify teeth)* Additional Review/Report by Radiologist

Comments: _____

- CD
- Email: _____

Mark appropriate areas of interest on tooth chart and/or anatomical model

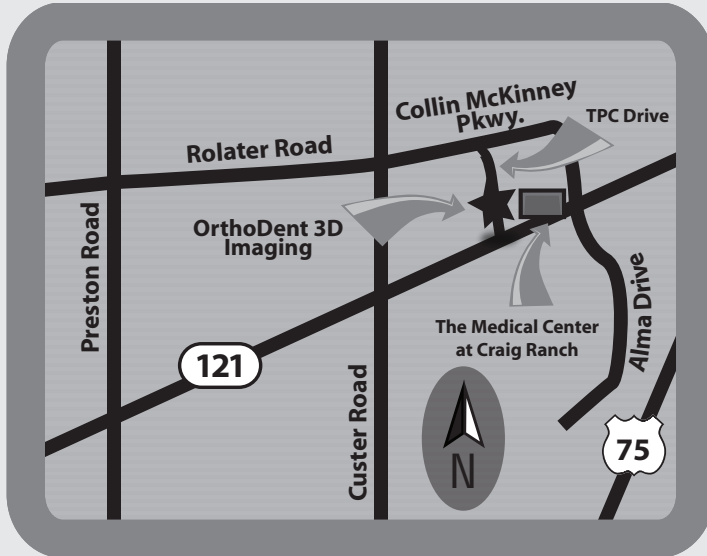


Referring Doctor Signature (Required) _____

Texas Dental License # _____

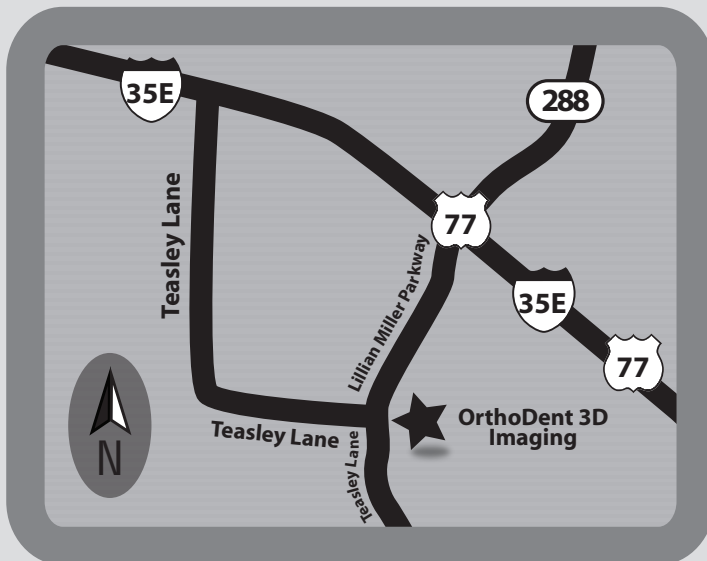
By signing above, I state that this procedure is medically necessary for this patient, and I request that OrthoDent 3D Imaging acquire the listed images, and that I have obtained authorization from the patient for these procedures.

McKINNEY



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Kindly give 24 hours notice if a change in scheduling is required.