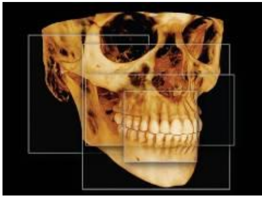

Precise 3D Imaging

14051 Burbank Blvd.,Van Nuys, CA 91401 T: (818) 785-0800 @: precise3dimaging@gmail.com

Referring Doctor: ______________________________ Signature: __________________
(Please Print)

Email: ____ Phone: (_____)______-_______

Patient Information: First Name: __________________ Last Name: ___________________

Date of Birth: ____/____/_______ Phone: (_____)______-_________

1. Specifications:

Area of concern:
□Implant □Periodontics □Pathology
□Orthodontics □Endodontics □TMJ
□Sinus Exam □Dental Impaction □Other ______________

2. Field of view requested:

□Full head (17X13) **□Full head (11X17)** **□Double Jaw (10X10)**
□Single Jaw (10X5) (*circle 1*) Upper / Lower
□Molar/pre./ant.(5X5) (*circle 1*) Upper / Lower

Location:

RT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	LT
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

Special Instructions:
____
____
____

3. Results Format:

□ Scan + Digital Report on (*circle 1*) CD / USB
□ Scan via email (*circle 1*) Zip / Dicom
□ Panoramic X-Ray (*circle 1*) emailed / mailed
□ PDF Report (*circle 1*) Printout / Email
□ Extras ($25 each) (*circle 1*) CD / Report printout

Mailing Address: ____

4. Bill To:

□ **Referring Doctor** □ **Patient** (payment due at time of service)

Consent: Please read carefully. By signing this form, you permit us to use and disclose your health information to perform imaging services, payment transactions, and healthcare activity. The prescribing doctor is responsible for diagnosis of the scan. Payment is due at the time of service. I hereby consent to receive dental service and accept full financial responsibility.

________________________ ________________________ ________________________
Print Patient Name | Patient or Representative Signature | Date

Map