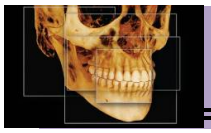

Precise 3D Imaging

14051 Burbank Blvd.,Van Nuys, CA 91401 T: (818) 785-0800 @: info@precise3dimagingcenter.com

Referring Doctor: _____ Signature: _____
(Please Print)

Email: _____ Phone: (_____)_____-_____

Patient Information: First Name: _____ Last Name: _____

Date of Birth: ____/____/_____ Phone: (_____)_____-_____

1. Specifications:

I. Special Instruction To Patient Before Scan:
_____

II. Scan Position: □Tight Occlusion □Non-Occluding □Separate Arches

III. 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) Upper/Lower **□Molar/pre./ant.(5X5)** 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 + Implant Planning Software (*circle*) 1 Arch / 2 Arches
□1 Scan + Digital Report on CD (*circle*) JPG / PDF
□Glossy Paper Report Printout
□Simplant reformat Scan + 1 Arch
□Nobel Guide Protocol
□Panoramic x-ray

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