MOBILE 3D IMAGING

RX FORM

Serving Southern California

PHONE: 800.985.9269
EMAIL: info@mobile3dimaging.com
WEB: mobile3dimaging.com

REQUIRED FIELDS

Patient Information

First Name _____ Last Name _____ Date of Birth _____

Phone # _____ Patient expecting our call to schedule? No ☐ Yes ☐ (Please inform patient of **(714)** area code!)

Doctor Information

Doctor name _____ Office Name _____

Office Phone # _____ Email to receive downloadable link _____

Please select one or more:

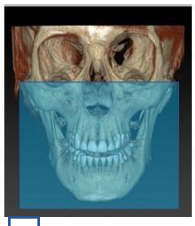
- ☐ **CBCT Scan any size… ~~$325~~ $280!***
- ☐ **CBCT Dual Scan Protocol…~~$360~~ $325!***
- ☐ **Panoramic Xray only…~~$185~~ $175!***
- ☐ **CBCT TMJ Open and Closed… $325**
- ☐ **CEPH + Pano… $300**

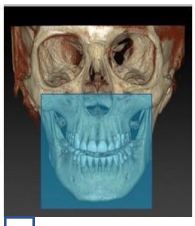
*Prices valid through August 2025

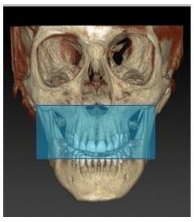
- Payment Required at Time of Appointment by ☐ Patient or ☐ Doctor. Credit/Debit Card Only, **NO Checks**
- 24-hour Cancelation Notice is REQUIRED or a $50 fee will be applied.

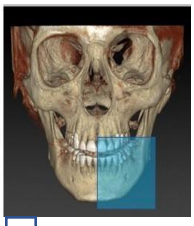
Scan Information

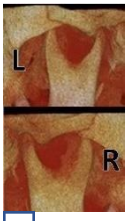

☐ Complete(15x13)


☐ Wide Scan(15x8)

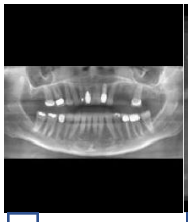

☐ Dual arches(10x8)

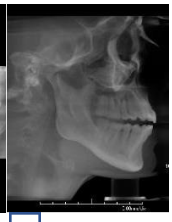

Single arch(10x5) ☐ max ☐ mand


☐ Single Site (5x5)



☐ TMJ only


☐ Panoramic only


☐ CEPH + Pano

- **Bite:** ☐ open ☐ closed ***OPEN BITE REQUIRED FOR SURGICAL GUIDES***
- **Radiology report:** ☐ NO ☐ YES **add $145** (3 days turnaround)

All scans will be uploaded same day in your private, HIPAA compliant cloud folder provided by us. You will receive an email with a link to download the scan file containing the *DICOM*, the *Interactive 3D Viewer* and *Instructions to use it*

OPTIONAL FIELDS

Mark if needed: ☐ cross-slicing PDF (in 24h), ☐ USB Drive or ☐ CD, ☐ cross-slicing prints, **add $50**, (5 days)
☐ Dual Scan Protocol, with fiducial markers (scan 1: patient with appliance, scan 2: appliance)
☐ DICOM ☐ Email DICOM to 3rd party, email address _____

Special focus: ☐ Orthodontics ☐ Endodontic Surgery ☐ Sinus Assessment ☐ Sleep Apnea Study
☐ Implants _____ ☐ Other _____

Teeth / Area:

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 ☐

Additional notes/requests _____

*** Please COMPLETELY fill out form and submit online via our website,

email: info@mobile3dimaging.com, or text to 714.224.8846!***

Authorization
Doctor signature: _____ Date: _____