MOBILE 3D IMAGING

RX FORM

Serving Southern California

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

REQUIRED FIELDS

Patient Information

First Name _____ Last Name _____ Date of Birth _____

Phone # _____ Patient expecting our call to schedule ☐ NO ☐ YES (inform patient of ***310*** area code calling)

Doctor Information

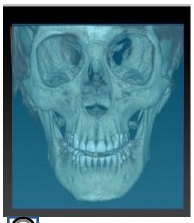
Doctor name _____ Office Name _____

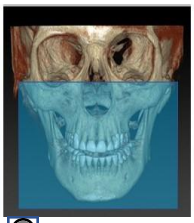
Office Phone # _____ Email to receive downloadable link_____

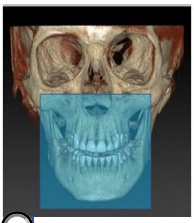
FEES: ***CBCT Single Scan, any size $275** ***CBCT Dual Scan Protocol $295** ***CBCT TMJ Open and Closed $295**
***Panoramic Xray $135** ***CEPH + Pano $275**

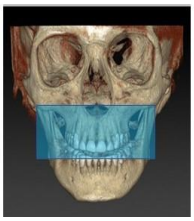
- **Payment Responsibility at Time of Appointment by ☐ Patient or ☐ Doctor. Credit/Debit Card Only**
- **24-hour Cancelation Notice is REQUIRED or a $50 fee will be applied.**

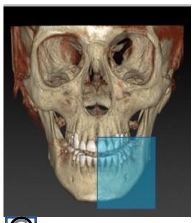
Scan Information

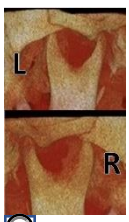

☐ Complete(15x13)


☐ Wide Scan(15x8)

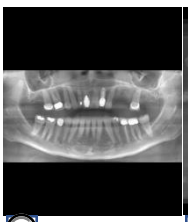

☐ Dual arches(10x8)

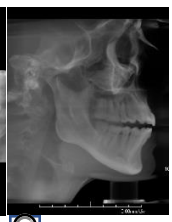

Single arch(10x5) ☐ max ☐ mand


☐ Single Site (5x5)



☐ TMJ only


☐ Panoramic only


☐ CEPH + Pano

- **Bite:** ☐ open ☐ closed ***OPEN BITE REQUIRED FOR SURGICAL GUIDES*****
- **Radiology report:** ☐ NO ☐ YES **add $85**, (7 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 (24h) ☐ cross-slicing prints, **add $50**, (5 days) ☐ CD
☐ Dual Scan Protocol, with fiducial markers, **add $20**, (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 _____

Authorization
Doctor signature: _____ Date: _____

*** **This form MUST be filled completely and either presented at the appointment, emailed to info@mobile3dimaging.com or filled/submitted online.*****