

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)

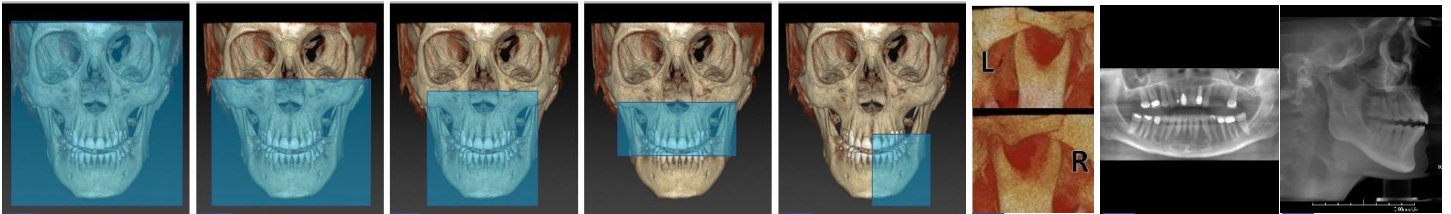
Doctor Information

Doctor name _____ Office Name _____
Office Phone # _____ Email to receive downloadable link _____

FEES: *CBCT Single Scan, any size \$295 *CBCT Dual Scan Protocol \$315 *CBCT TMJ Open and Closed \$315
*Panoramic Xray \$135 *CEPH + Pano \$295

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

Scan Information



Complete(15x13) Wide Scan(15x8) Dual arches(10x8) Single arch(10x5) Single Site (5x5) TMJ only Panoramic only CEPH + Pano
 max mand

- Bite: open closed ***OPEN BITE REQUIRED FOR SURGICAL GUIDES***
 - Radiology report: NO YES add \$85, (10 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.***