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 ***714*** area code calling)

Doctor Information

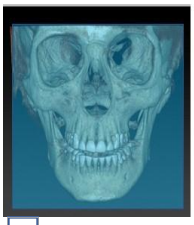
Doctor name _____ Office Name _____

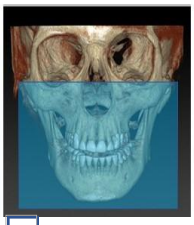
Office Phone # _____ Email to receive downloadable link_____

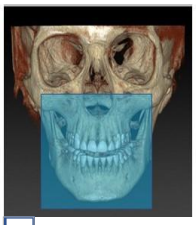
Please select one or more:
- ☐ **CBCT Scan any size… $325**
- ☐ **CBCT Dual Scan Protocol single arch… $360**
- ☐ **CBCT Dual Scan Protocol dual arch… $395**
- ☐ **Panoramic Xray only… $185**
- ☐ **CBCT TMJ Open and Closed… $360**
- ☐ **CEPH + Pano… $360**

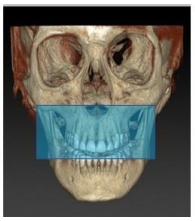
- Payment Required at Time of Appointment by ☐ Patient or ☐ Doctor. Credit/Debit Card Only, **NO Checks**
- 24-hour Cancelation Notice is REQUIRED or a $50 fee will be applied.

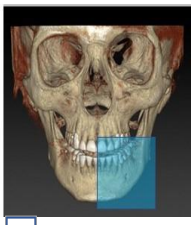
Scan Information

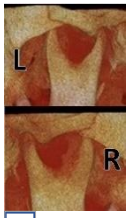

☐ **Complete(15x13)**


☐ **Wide Scan(15x8)**

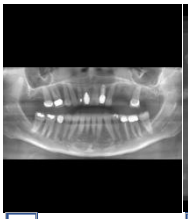

☐ **Dual arches(10x8)**

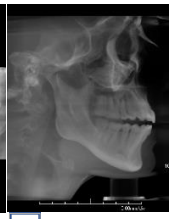

Single arch(10x5) ☐ **max** ☐ **mand**


☐ **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 _____

*** **This form MUST be completely filled and submitted online or emailed to info@mobile3dimaging.com or text picture to 714.224.8846*****

Authorization
Doctor signature: _____ Date: _____