

**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)

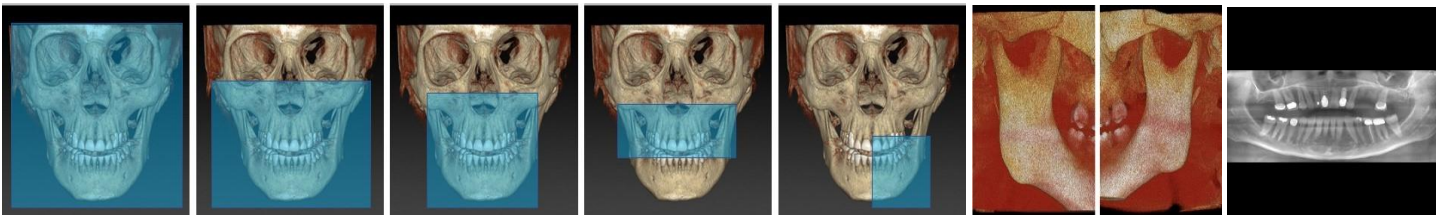
**Doctor Information**

Doctor name \_\_\_\_\_ Office Name \_\_\_\_\_  
Office Phone # \_\_\_\_\_ Email to receive downloadable link \_\_\_\_\_

Fees: CBCT Scan, any size \$225 Panoramic Xray \$115 Radiology Report \$85 Prints \$50

- 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  
 max  mand

- Bite:  open  closed **\*\*\*OPEN BITE REQUIRED FOR SURGICAL GUIDES\*\*\***
- Radiology report:  NO  YES (add \$85, 5-7 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, 3 days)  CD  
 Dual Scan Protocol, with fiducial markers (scan 1: patient with appliance, scan 2: appliance)  
 DICOM only  Email DICOM to 3<sup>rd</sup> 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.\*\*\***