Request for Advanced Imaging Services

Patient Information **Date** ____________________

Name:	Date of Birth:
Street Address / City / State / Zip:	Phone:
email:	Gender: ☐ Male ☐ Female

Consultant

Name:	National Provider Identifier (NPI) #:
Street:	Phone/Fax:
City/State/Zip:	email:

Circle Requested Imaging Survey Code ☐ Radiographic stent needed for scan

ADA D0364 - Limited FOV; less than one jaw $186.00

D0365 - CBCT FOV; full dental arch – mandible.................. $265.00

D0366 - CBCT FOV; full dental arch – maxilla with-w/out cranium.................. $265.00

D0367 - CBCT FOV; both dental arches – with-w/out cranium.................. $318.00

D0368 - CBCT – TMJ series; > 2 exposures.................. $318.00

D0391 - CBCT – Interpretation of submitted data with report.................. $90.00

CPT 70486 - Computed tomography, maxillofacial area without contrast $318.00

Panoramic Radiography

ADA D0330 - Panoramic radiography $125.00

CPT CPT 70355 – Panoramic radiography $125.00

ADA D0290 – Skull radiography - Lateral or PA..................$95.00

ADA ADA D0340 - Cephalometric radiography - Lateral or PA..................$95.00

CPT CPT 70250 - Skull radiography - Lateral or PA $95.00

Reason(s) for Request and preliminary impressions ____________________

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Pertinent Dental History

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Pertinent Dental History

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Consultant's signature ____________________

Date ____________________