



Dental CT Imaging Centers – Scan & Image Processing Rx

All studies include a radiologist's report

Pt. Name _____ Referring Dr: _____

Pt. Address _____ Dr. Address: _____

Pt. Phone: () _____ - _____ Dr. Phone: () _____ - _____

Pt. Mobile: () _____ - _____ Dr. Fax: () _____ - _____

E-mail: _____ E-mail: _____

3D Dental CT Ceph + Mixed Dentition **Need by** (circle one): MO TU WE TH FR SA SU AM/PM

Indicate Teeth or Area of Interest

R	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	L
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

Type of Study: (please check all that apply)

IMPLANTS: Mandible Maxilla Both arches Sinus graft
Appliance: NobelGuide BMI VIP Other _____
(Note: BMI & NobelGuide require double or triple scans)

DIAGNOSTIC: impacted tooth # _____ sinus pathology cysts/tumor
 craniofacial trauma paresthesia ENDODONTIC tooth # _____

ORTHODONTIC: Ceph + mixed dentition other (specify _____)

TMJ: Open Closed Both

Sleep Apnea: airway evaluation

Follow-up APW scan (of the same arch) to evaluate:
 implants sinus graft ridge augmentation other _____

DELIVERY FORMAT (select one): Digital: Internet (fastest delivery) CD
Hard Copy: Prints Film

DIGITAL SOFTWARE: I-Vision VIP NobelGuide (2 scans)
SimPlant® version: 8 9 10 11 View only
SimPlant® noise reduction (CD/Internet) Color sep. + noise reduction

Comments/history about area of interest: _____

Medical insurance claims must be accompanied by a diagnosis and ICD9 code provided by the referring dentist. For common codes visit: <http://i-dontics.com/dentists/dentalcodes.shtml>

Diagnosis: _____ ICD9 code _____

Doctor's signature _____ License # _____ Date: _____

For a complete listing of i-dontics Dental CT Imaging Center locations visit:
<http://www.i-dontics.com>